

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

11884

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11875

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE	
Talbot		MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Rural - St. Michaels 6 1/2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - St. Michaels	
3. NAME OF DECEASED (Type or print)		First NATHAN	Middle
4. DATE OF DEATH		Month 8	Day 9
5. SEX		5. COLOR OR RACE Colored	6. MARRIED WIDOWED
7. NEVER MARRIED DIVORCED		7. MARRIED NEVER MARRIED	8. DATE OF BIRTH Feb. 11, 1901
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY LABORER	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
11. BIRTHPLACE (County & State, or foreign country) Talbot, Md		12. CITIZEN OF WHAT COUNTRY? USA	11b. ADDRESS
13. FATHER'S NAME MELINDA Adams		14. MOTHER'S MAIDEN NAME JAMES Adams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-05-1738A	17. INFORMANT Norwood Caldwell McDaniel, Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Myocardial infarction atherosclerotic coronary atherosclerosis	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			1953, 19, 8-3-66
21. I certify that (I) (this hospital) attended the deceased from 1953, 19, 8-3-66, that (I) (we) last saw the deceased alive on 8-3-66, and that death occurred at 3 PM, from the causes and on the date stated above.			
22a. SIGNATURE R. M. Beeson		22b. DATE SIGNED 8-15-66	
22c. PHYSICIAN'S NAME (Type) R. M. Beeson		22d. ADDRESS St. Michaels, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-13-66	
23c. NAME OF CEMETERY OR CREMATORIAL McDaniel Cemetery		23d. LOCATION (City, town or county) Talbot, Md	
24. FUNERAL DIRECTOR James B. Hashell		24d. ADDRESS Easton, Md.	
25a. REC'D BY REGISTRAR Aug 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

Octopus sagitta
several small
yellowish brown

FOR STATE
HEALTH DEPT.

necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMB/ Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11885

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RC @ 11885 AM

1. PLACE OF DEATH a. COUNTY <i>TALBOT</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>QUEEN ANNE'S</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BOSTON</i>		c. LENGTH OF STAY IN 1b <i>9 1/2 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CENTREVILLE</i>		d. STREET ADDRESS <i>102 Garden Lane</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Elizabeth Estelle Arthur</i>		First	Middle	Lost	4. DATE OF DEATH Month <i>8 - 10</i>	Day <i>19</i>	Year <i>66</i>	
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>August 17, 1879</i>	9. AGE (In years last birthday) <i>86 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED ARTIST</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>ILLUSTRATION COMMERCIAL</i>		11. BIRTHPLACE (State or foreign country) <i>NEW YORK CITY, N.Y.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13. FATHER'S NAME <i>Edward Arthur</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ostrandier</i>		Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>201-01-6177T</i>		17. INFORMANT <i>Mrs. GRACE H. Hatfield, Queenstown Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>9210</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Meat lodged in Esophagus</i> DUE TO (c) <i>Aspiration Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hr</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Advanced Arteriosclerotic Disease</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>Meat lodged in Esophagus</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Centreville QA Md</i>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>Aug 8 1966</i>		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Centreville QA Md</i>		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>C.R. Layton</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>Aug 16, 1966</i>		
EXAMINER'S NAME (Type) <i>C.R. Layton</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <i>Centreville, Md.</i>		23a. BURIAL, CREMATION, (Specify) <i>Burial</i>		
23b. DATE THEREOF <i>August 13, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Forest Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>DUNMORE PENNA</i>				
24. FUNERAL DIRECTOR ADDRESS <i>Jessell B. Buttry Jr., Barton Bros, Centreville, Md.</i>		25a. RECEIVED BY REGISTRAR <i>DATA AUG 15 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

921

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11886

CERTIFICATE OF DEATH

11881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		b. COUNTY <i>Talbot</i>	
c. LENGTH OF STAY IN 1b <i>6 da.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>rural Easton</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>		d. STREET ADDRESS <i>R. D. #4 Kirkland Farm</i>	
3. NAME OF DECEASED (Type or print) <i>Cecil Franklin</i>		4. DATE OF DEATH Last <i>Backus</i>	Month Day Year <i>8 30 1966</i>
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 6, 1885</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Broker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>investment</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Norfolk Co., Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William Backus</i>		14. MOTHER'S MAIDEN NAME <i>Anna Hall</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>221-14-7008</i>	
17. INFORMANT <i>Mrs. Alice C. Backus</i>		Address <i>Easton, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intestinal Pulmonary fibrosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>b</i> <i>c</i>		DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>factory</i>
20f. (City or town) <i>Easton</i>		(County) (State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____ and that death occurred at <i>12:45 P.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>30 Aug 66</i>	
22a. SIGNATURE <i>E.C.H. Schmidt</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>		22d. ADDRESS <i>Easton, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>Aug. 31, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln</i>		23d. LOCATION (City, town or county) (State) <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR <i>Maurice E. Newman & Son</i>		ADDRESS <i>Easton, Md.</i>	
25a. REC'D BY REGISTRAR <i>SEP 2 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judy</i>	

18811

PALMER 100-1000

18811

MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11887 11882

1. PLACE OF DEATH e. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) e. STATE Virginia b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON DOA 4:30P		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Norfolk	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (First Middle Last) ANDREW LEE BOWSER		4. DATE OF DEATH AUG 30 1966	
3. NAME OF DECEASED (First Middle Last) ANDREW LEE BOWSER		5. SEX MALE	
6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH 1908 MAR. 16, 1908	
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years) 68 yrs. IF UNDER 1 YEAR Months Dey 1968 IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Richmond Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry H. Bowser		14. MOTHER'S MAIDEN NAME Betty L. Bland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of Aneurysm of Aorta DUE TO Conditions, if any, which gave rise to immediate cause (b) (c)		INTERVAL BETWEEN ONSET AND DEATH IMMED.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Lewis J. Welty</i> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) WELTY FOR PRACTICE MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9-4-66		22c. NAME OF CEMETERY OR CREMATORIUM Norfolk Cemetery 22d. LOCATION (City, town, or country) Norfolk (State) Virginia	
23. FUNERAL DIRECTOR James B. Haskell Easton, Md.		ADDRESS ADDRESS 24e. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE SEP 7 1966 Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained by your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 will be the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/62

5
S
O
C
I
E
T
Y
U
N
I
O
N

1911. 10. 1. 1911. 10. 1. 1911. 10. 1.

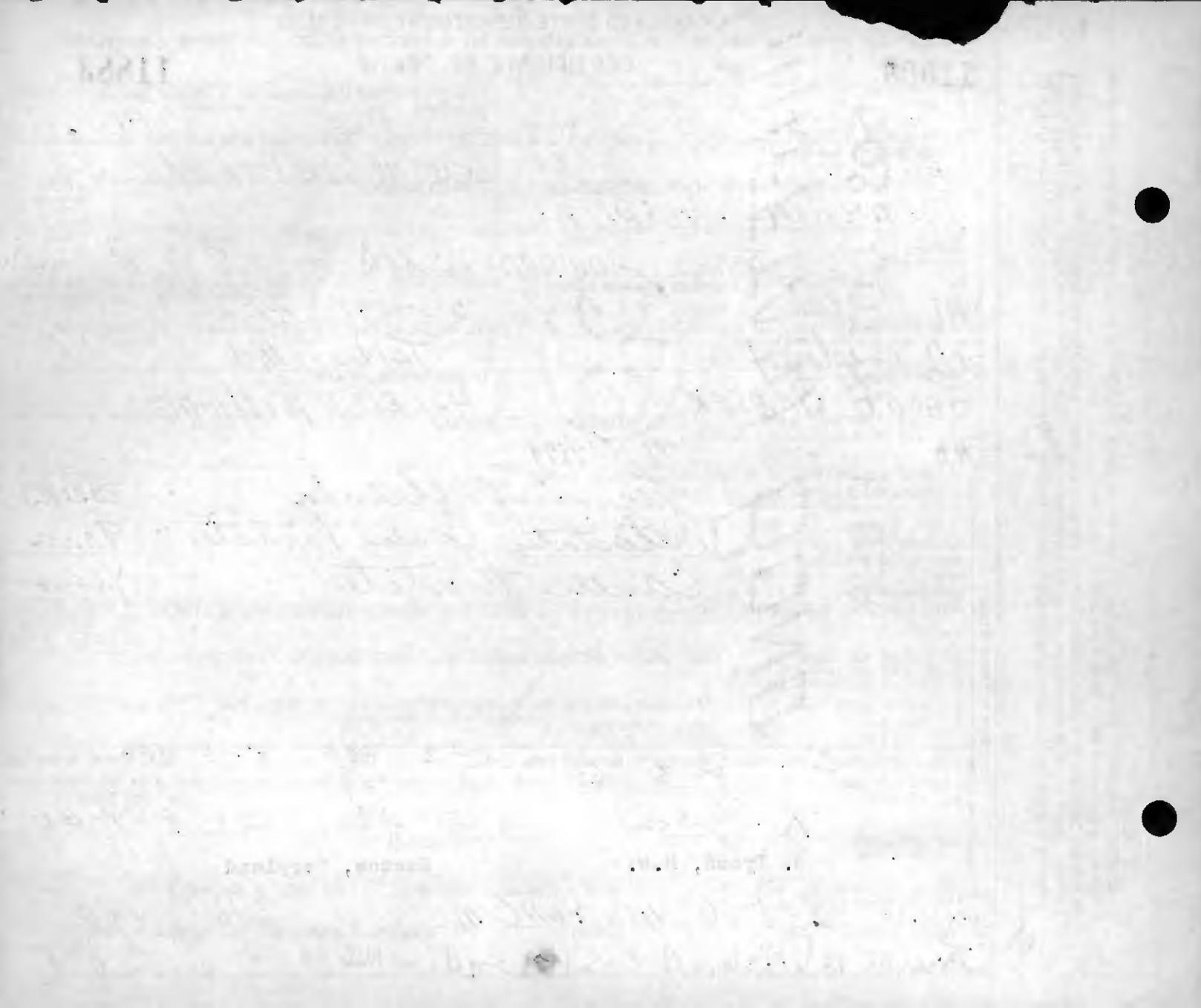
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

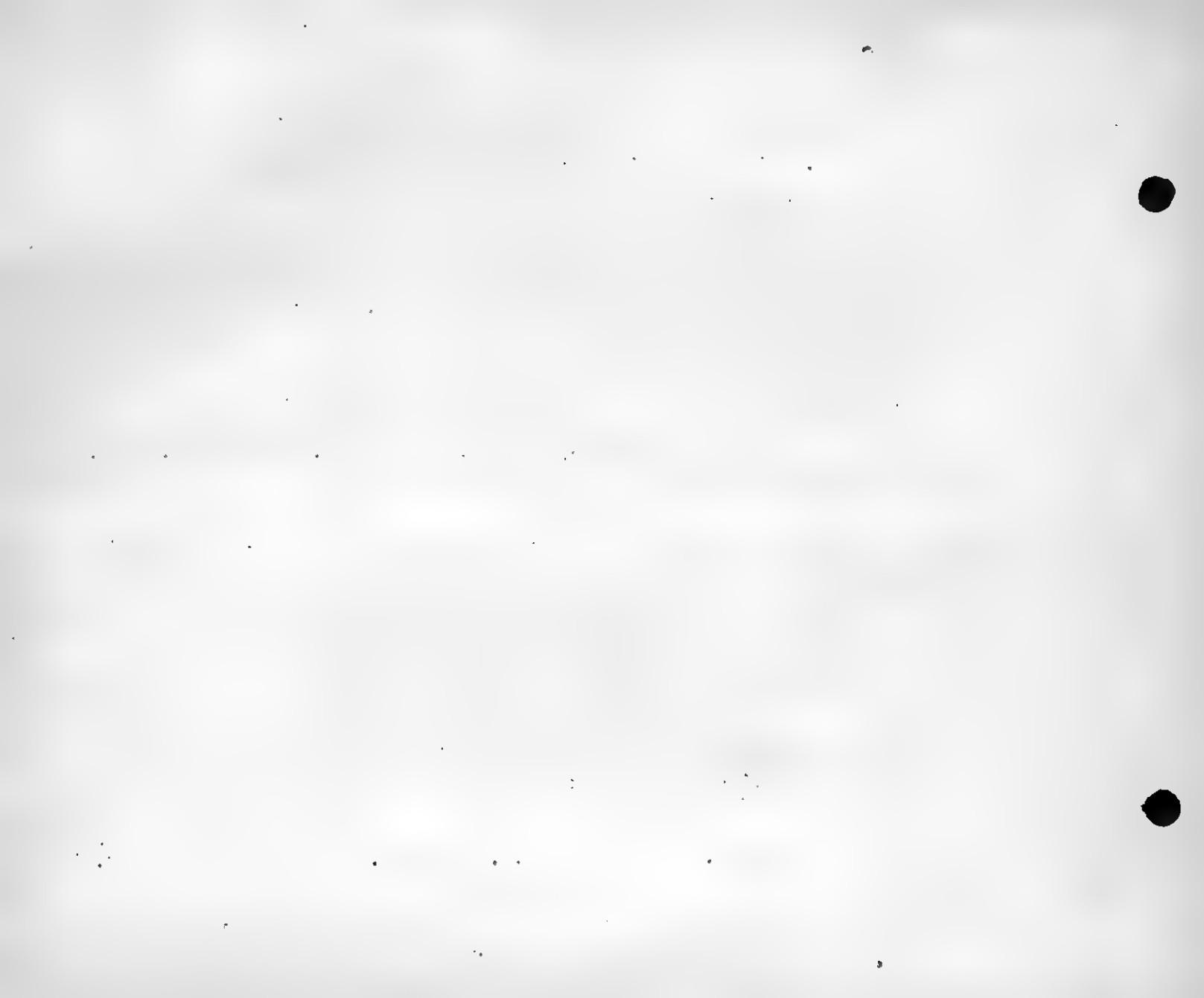
11888		11883	
1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b 8 hr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cordova Rd, Talbot d. STREET ADDRESS 20-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JAMES	Middle EDWARD	Last BOWSER
4. DATE OF DEATH	Month 8	Day 3	Year 1966
5. SEX M	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/1891
		WIDOWED <input type="checkbox"/>	9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Talbot, Md		12. CITIZEN OF WHAT COUNTRY? Md	
13. FATHER'S NAME Jacob Bowser		14. MOTHER'S MAIDEN NAME HARRIET WILLIAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 177-10-4854	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 197X			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.			
DUE TO (b) Terminal Uremia			
DUE TO (c) Metastatic Cancer Prostate			
DUE TO (c) Cancer Prostate			
INTERVAL BETWEEN ONSET AND DEATH weeks			
9mos.			
Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Easton (County) Md (State) Md
21. I certify that (I) this hospital attended the deceased from 8-3 , 19 66 , to 8-3 , 19 66 , that (I) (we) last saw the deceased alive on 8-3 19 66 , and that death occurred at 8-3 M, from the causes and on the date stated above.			
22a. SIGNATURE R. Tyson		22b. DATE SIGNED 8-4-66	
22c. PHYSICIAN'S NAME (Type) R. Tyson, M.D.		22d. ADDRESS Easton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-8-66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS NEWTON CEM		23d. LOCATION (City, town or county) Talbot, Md (State) Md	
24. FUNERAL DIRECTOR James B Dashiel Easton and		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE	
		DATE AUG 8 1966	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												11884			
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY			11829 Talbot MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			a. STATE Maryland b. COUNTY Kent						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2			Easton 1/4 days			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Rural Millington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			Memorial Hospital			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?			None			
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			Month	Day	Year	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX			6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH			9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	Months	Days	Hours	Min.
Male			White	WIDOWED	<input checked="" type="checkbox"/>	April 26, 1898			68 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?			Maryland			
Retired Farmer			None			Maryland			USA						
13. FATHER'S NAME			Elie Bridles			14. MOTHER'S MAIDEN NAME			Frances Pierce						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address						
No			218-34-0351			Harvey Rochester Phila., Pa.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dementia</i>												4 weeks			
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic renal disease</i>												2-3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
19															
21. I certify that (I) (this hospital) attended the deceased from <i>31 July</i> , 1966, to <i>10 Aug</i> , 1966, that (I) (we) last saw the deceased alive on <i>Aug 10 1966</i> , and that death occurred at <i>855</i> M, from the causes and on the date stated above.												22b. DATE SIGNED <i>11 Aug 66</i>			
22a. SIGNATURE <i>Stephen P. Carney</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type)			M.D.			22d. ADDRESS			Easton, Maryland			11 Aug 66			
Stephen P. Carney						230. LOCATION (City, town or county) (State)									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			Marydel, Maryland						
Burial			8-13-66			Mt. Zion									
24. FUNERAL DIRECTOR									25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
<i>J. E. Boulaire Greensboro, Md.</i>									DATE AUG 15 1966			<i>Charles Judge</i>			
VR A15 (4) 20M 1/65															



1 M

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11840				11885	
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission) a. STATE <i>MARYLAND</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1B <i>14 hrs 45 min</i>		b. COUNTY <i>TALBOT</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Easton Memorial Hosp.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL CORDOVA</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Ruth Clara Callahan</i>		First	Middle	Last	4. DATE OF DEATH <i>August 25 1966</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>6-11-1915</i>	9. AGE (In years last birthday) <i>54 yrs.</i> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <i>2 months 14 days 14 hours 14 minutes</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>OFFICE MGR</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>H.S.Govt. AGRICULTURAL</i>		11. BIRTHPLACE (County & State, or foreign country) <i>TALBOT, MD</i>	
13. FATHER'S NAME <i>BERNARD F. CALLAHAN</i>		14. MOTHER'S MAIDEN NAME <i>MARY H. GOLT</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-32-0911</i>		17. INFORMANT Address <i>Miss LOLETA CALLAHAN - CORDOVA, MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma</i>				INTERVAL BETWEEN DNSEF AND DEATH <i>10-6 505</i>	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>171X</i>		DUE TO (b)	(primary carcinoma of cervix)		
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> 20d. INJURY OCCURRED Not While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>405</i> M, from the causes and on the date stated above.		22b. DATE SIGNED <i>Robert W. Trevor</i>			
22a. SIGNATURE <i>Robert W. Trevor</i>		22b. DATE SIGNED <i>Robert W. Trevor</i>			
22c. PHYSICIAN'S NAME (Type) <i>ROBERT W. TREVOR</i>		22d. ADDRESS <i>FASTON</i>			
23a. BURIAL/CREMATION, REMOVAL (Specify) <i>8-29-66</i>		23b. DATE THEREOF <i>8-29-66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>OLD ST JOSEPHS</i>	23d. LOCATION (City, town or county) (State) <i>CORDOVA MD</i>	
24. FUNERAL DIRECTOR <i>Reli-Belt</i>		ADDRESS <i>Easton</i>	25a. REC'D BY REGISTRAR <i>AUG 30 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			11886		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				a. STATE Md.				b. COUNTY Talbot					
Jalbot MARYLAND				c. LENGTH OF STAY IN 1B				c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town)				Rural Trappe,					
b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town)				d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Easton life Memorial Hospital																	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year									
Richard E. Collins					8	23		1966									
5. SEX		6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS								
M		W	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	7/3/1882	84 yrs.	Months	Days	Hours	Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY? USA					
Mail carrier								Talbot, Md.									
13. FATHER'S NAME												14. MOTHER'S MAIDEN NAME					
unk.												unk.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address					
no				214-16-4362				Earl T. Collins				Trappe, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42.21												cocklefield 1mo					
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.												due to atherosclerotic cardio and cerebro vasc. advanced					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) senile changes. venous cardiac failure																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION				20c. TIME OF INJURY	Month, Day, Year	Hour a.m.	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)						
						p.m.	While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>										
21. I certify that (I) (this hospital) attended the deceased from 7-29, 1966 to 8-7, 1966, that (I) (we) last saw the deceased alive on aug 27 1966, and that death occurred at 8:15 M, from the causes and on the date stated above.								22b. DATE SIGNED									
22a. SIGNATURE								M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 8-28-66									
22b. PHYSICIAN'S NAME (Type)				22d. ADDRESS													
Burial, Cremation Removal (Specify)				23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill				23d. LOCATION (City, town or county)				(State)					
burial 8/30/66								Easton Md.									
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Ray D. Houston, Easton, Md.								DATE AUG 31 1966				Charles Judge					
VR A15 (4) 20M 1/65																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

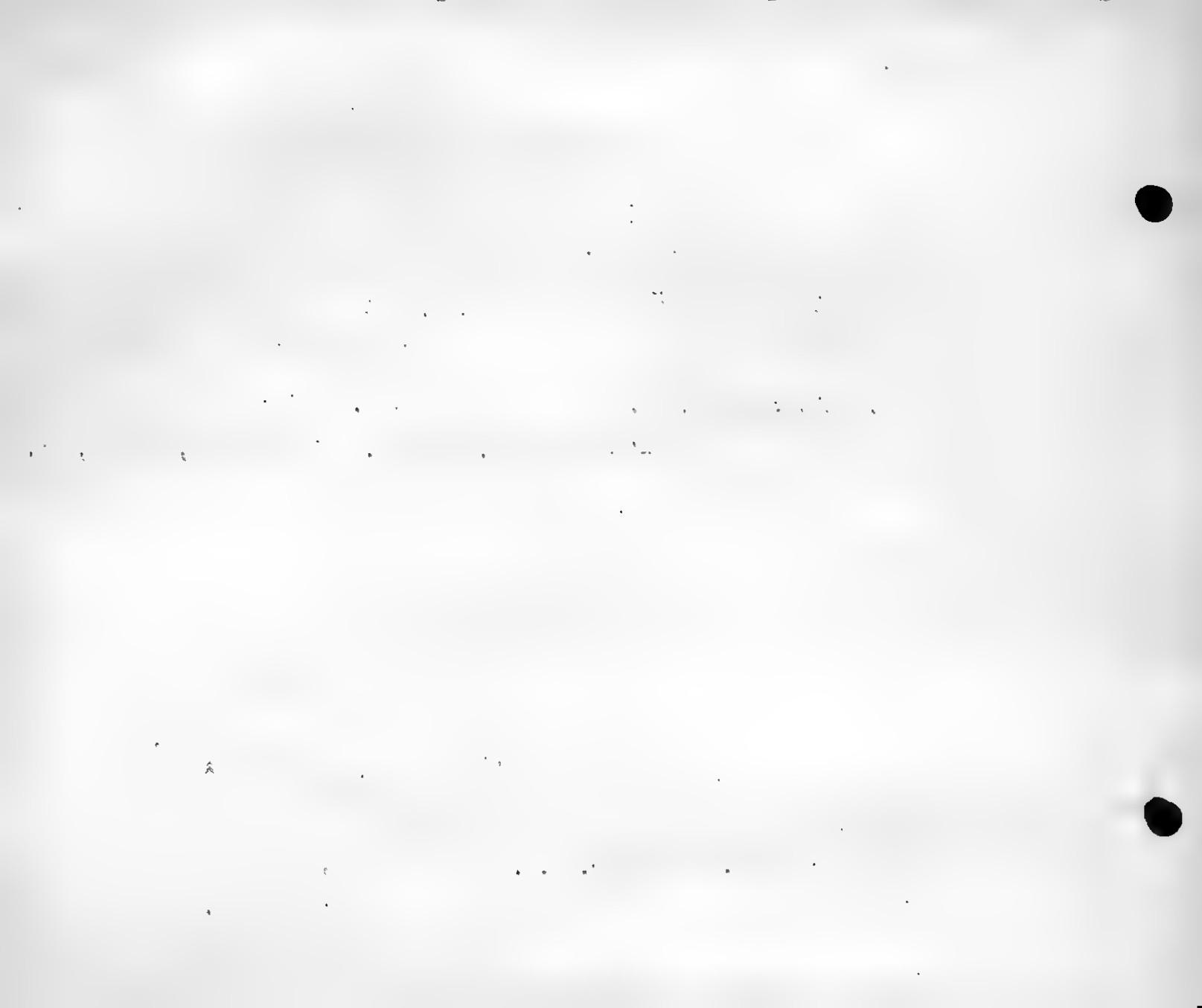
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11892

CERTIFICATE OF DEATH

11887

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>Maryland</i>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oxford</i>	c. LENGTH OF STAY IN lb c. LENGTH OF STAY IN lb <i>8 dn</i>													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <i>James</i>	First <i>Kix Neff</i>	Middle <i>Crickenberger</i>	Last <i>Crickenberger</i>	4. DATE OF DEATH <i>8-22 1966</i>	Month <i>8</i>	Day <i>22</i>	Year <i>1966</i>							
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/14/1942</i>	9. AGE (In years last birthday) <i>24 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>	13. FATHER'S NAME <i>Henry N. Crickenberger, Jr.</i>	14. MOTHER'S MAIDEN NAME <i>Susie A. Robins</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	16. SOCIAL SECURITY NO. <i>228-50-0098</i>	17. INFORMANT <i>Mrs. James N. Crickenberger, Oxford, Md.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mediastinal teratoma, strangled</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2 mo.</i>
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>169X</i>	DUE TO (b) <i></i>	DUE TO (c) <i></i>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>August 22, 1966</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i>Oxford</i>	(County) <i>Oxford</i>	(State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>July 7, 1966</i> , to <i>August 21, 1966</i> , that (I) (we) last saw the deceased alive on <i>August 21, 1966</i> , and that death occurred at <i>2 p.m.</i> from the causes and on the date stated above.						22a. SIGNATURE <i>Arthur B. Cecil, Jr. M.D.</i>	22b. DATE SIGNED <i>August 22, 1966</i>							
22c. PHYSICIAN'S NAME (Type) <i>Arthur B. Cecil, Jr. M.D.</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Select) <i>Burial</i>	23b. DATE THEREOF <i>8/25/1966</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Oxford Cemetery</i>	23d. LOCATION (City, town or county) <i>Oxford, Md.</i>	(State) <i>Md.</i>										
24. FUNERAL DIRECTOR <i>Arthur E. Mizrahi, Esq. (notarized)</i>	ADDRESS <i>110 Main Street, Easton, Maryland</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11893 **11888**

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)									
Talbot		Maryland		MD		a. STATE MARYLAND		b. COUNTY TALBOT							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		EASTON		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		EASTON							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		MEMORIAL HOSPITAL		d. STREET ADDRESS		519 PLEASANT PL.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. KIN OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HUNWIG	J.	EGISEDER SR.	8	28	1966	W	WOOED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	MAY 20, 1887	80 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIN OF BUSINESS OR INDUSTRY	GERMANY	USA	
13. FATHER'S NAME	RET. BAKER		FOOD		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
Alois EGLSEDER	No		217-01-8624		ANNA EGLSEDER		-		-		EASTON, MD		619 PLEASANT PL.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 8-21-66									
252X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	Cerebral arteriosclerosis		Unknown										
		DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Gangrene rt. gt. toe. Arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNOVERTLY INC <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 8-9, 1966, to 8-28, 1966, that (I) (we) last saw the deceased alive on 8-28, 1966, and that death occurred at 4 PM, from the causes and on the date stated above.		22a. SIGNATURE Robert W. Trever		22b. DATE SIGNED 8/29/66		22c. PHYSICIAN'S NAME (Type) Robert W. Trever		22d. ADDRESS M.D. Easton, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 31 1966		23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL Olive Cemetery		23d. LOCATION (City, town or county) Mt. Michael, Md.	
24. FUNERAL DIRECTOR Hamilton Harrison, St. Michaels		ADDRESS Md.		25a. REC'D BY REGISTRAR SEP 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																												
CERTIFICATE OF DEATH																												
11894		11889																										
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)																										
Maryland		a. STATE		b. COUNT		Maryland																						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Grasonville																						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																								
3. NAME OF DECEASED (Type or print): Jcs. J. William Alfred Evans		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR yrs.	11. IF UNDER 24 HRS Months	12. IF UNDER 24 HRS Days	13. FATHER'S NAME	14. MOTHER'S MOTHER'S MAIDEN NAME	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	Address	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marina owner-operator	10b. KIND OF BUSINESS OR INDUSTRY Boating	11. BIRTHPLACE (County & State, or foreign country) Grasonville, Queen Anne's County, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cerebral thrombosis left hemiplegia and multiple small cerebral thromboses										INTERVAL BETWEEN ONSET AND DEATH 2 months																
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)																		
21. I certify that (I) (this hospital) attended the deceased from 3 Aug 66 to 27 Aug 66, that (I) (we) last saw the deceased alive on 27 Aug 66, and that death occurred at / / M, from the causes and on the date stated above.		22a. SIGNATURE Harrison										22b. DATE SIGNED 30 Aug 66																
22c. PHYSICIAN'S NAME (Type) HARVESTON HARRISON		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS Caston May Lane																								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 30, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Chesterfield Cemetery		23d. LOCATION (City, town or county) Centreville Maryland		(State)																				
24. FUNERAL DIRECTOR John H. Burton Jr., Burton Bros., Centreville, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE																						



1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11885

11890

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2. PLACE OF DEATH a. COUNTY		11. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (CITY, TOWN OR COUNTY) (State)	
TALBOT		8-13		SPRING HILL		EASTON MD			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
EASTON		R. E. Beck		Dr. David C. Jones		AUG 15 1966		Charles J. George	
c. LENGTH OF STAY IN 1b		25c. DATE							
10 days.		AUG 15 1966							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		26. IS RESIDENCE ON A FARM?							
Memorial Hospital		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Annie Kenee Fairbank					8 - 11 - 1966				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS		
F		W	WIDOWED <input checked="" type="checkbox"/> DIVDRCD <input type="checkbox"/>	1-14-1881	85 yrs.	Months	Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
RETIRED		HOUSEWIFE		TALBOT MD		U.S.A			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
SAMUEL HENRY BENSON		SALLIE ANN COOPER							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		None		Mrs. CAROLINE POOLE EASTON		305 S. HANSON			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		Urinary infection				6 weeks	
104X		(b)							
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		DUE TO							
Severe arteriosclerosis		(b)							
(c)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that (I) (this hospital) attended the deceased from Jun 1966, to 11 Aug 1966, that (I) (we) last saw the deceased alive on 10 Aug 1966, and that death occurred at 8 PM, from the causes and on the date stated above.									
22a. SIGNATURE		22b. DATE SIGNED							
Stephen P. Conroy		11 Aug 66							
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS							



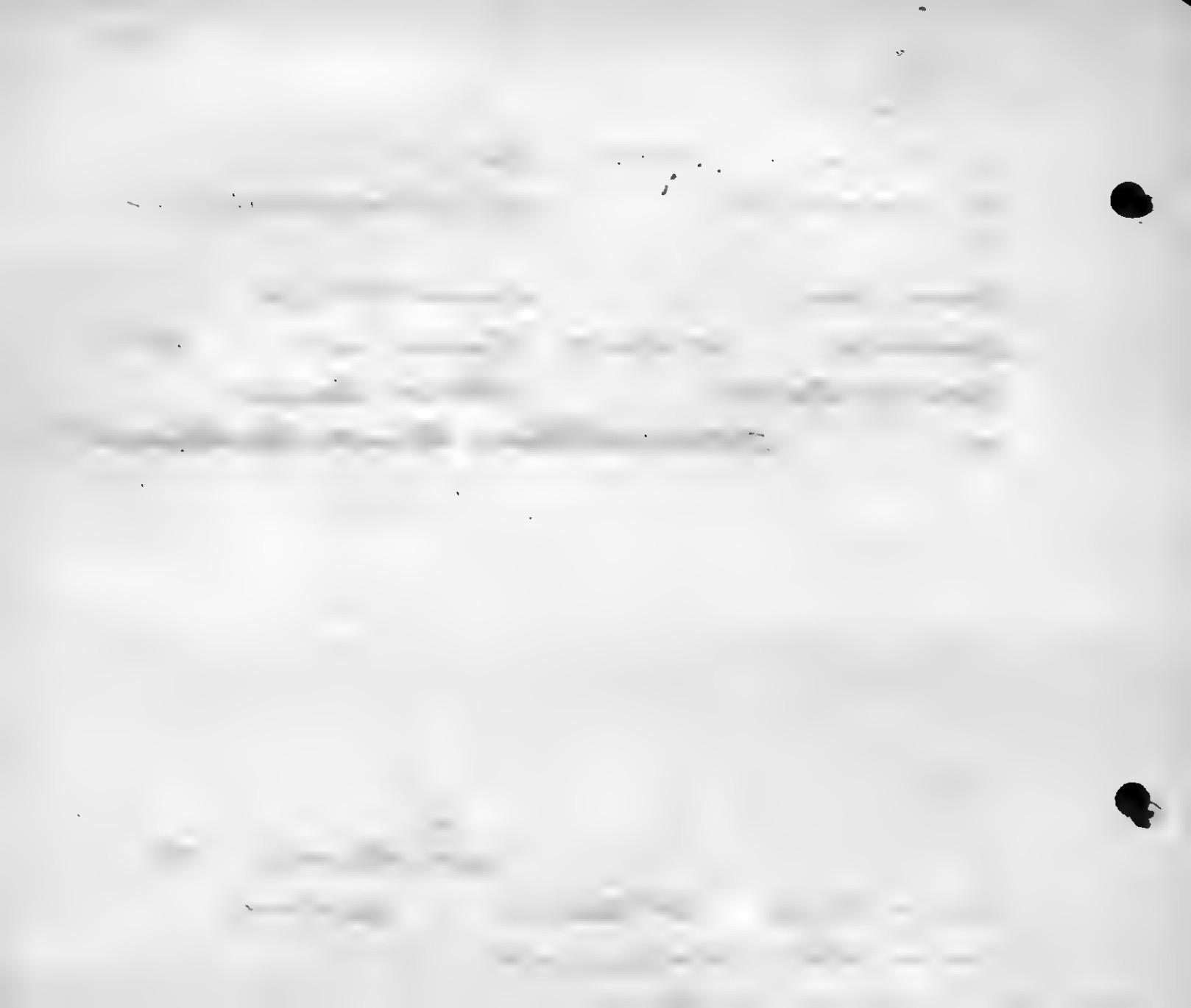
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed in the funeral director's office as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1III (4)
15M 9/59

PLACE OF DEATH o. COUNTY		TALBOT MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institut on Residence before admission)	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St MICHAELS</i>		c. LENGTH OF STAY IN 1b <i>1 wk</i>		o. STATE <i>MD</i>	
d NAME OF HOSPITAL (If not in hospital, give street address) o. INSTITUTION <i>OFF CHURCH N.W. Rd</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		b. COUNTY	
3 NAME OF DECEASED (Type or print) <i>Katie</i>		f. FIRST MIDDLE <i>First B</i>		d. STREET ADDRESS <i>3900 Edmondson Ave</i>	
5 SEX <i>Female</i>		6. COLOR OR RACE <i>Colored</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>July 28-1885</i>		9. AGE (in years lost birthday) <i>81 yrs.</i>		10. DATE OF DEATH <i>August 4 1966</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOMESTAKER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Raleigh N.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>WESLEY BRODIE</i>		14. MOTHER'S MAIDEN NAME <i>NELLIE Brodie</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>577-36-0214</i>		17. INFORMANT <i>Peacey Palmer</i>		Address <i>3900 Edmondson Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o.) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		COPULSION Generalized Thrombosis Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH <i>48 hr</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred on <i>Aug 05 1966</i> from the causes and on the date stated above.					
22a. SIGNATURE <i>R. Paul Whaley</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>8-4-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>St Michaels MD</i>					
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/8/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St Auburn</i>	
23d. LOCATION (City, town or county) <i>Bethel Md</i>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Margarete P. Judge</i>		ADDRESS <i>638 N Glemon St</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 5 1966</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT								
TALBOT MARYLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MICHAELS								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b 14 days.								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS GRACE ST.,								
3. NAME OF DECEASED (Type or print) John William Hanrahan				First John	Middle William	Last Hanrahan	4. DATE OF DEATH 8-6-66	Month 8	Day 6	Year 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE				6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1899	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 0	Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BET. MET. POLICE				10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.				11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.				12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JAMES FRANCIS HANRAHAN				14. MOTHER'S MAIDEN NAME NETTIE DOVE				Address ST. MICHAELS MD.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? YES WW I				16. SOCIAL SECURITY NO. 577-42-7163				17. INFORMANT Mrs. PAULINE H. HANRAHAN,				18. INTERVAL BETWEEN ONSET AND DEATH 14 days
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction												
7201 Ccnditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b)				DUE TO (b)								
(c)				DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) Easton (County) Md. (State) Maryland
21. I certify that (I) (this hospital) attended the deceased from 23 July 1966 to 6 Aug 1966 , that (II) (we) last saw the deceased alive on 6 Aug 1966 , and that death occurred at 9 AM , from the causes and on the date stated above.												
22a. SIGNATURE Stephen P. Carney				22b. DATE SIGNED 6 Aug 66								
22c. PHYSICIAN'S NAME (Type) Stephen P. Carney, Jr.				22d. ADDRESS Easton, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF Aug 9, 1966				23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATL. CEM.				23d. LOCATION (City, town or county) F.T. MYERS, VA. (State)
24. FUNERAL DIRECTOR Samuelton & Son, St. Michaels				ADDRESS St. Michaels, Md.				25a. REC'D BY REGISTRAR Charles Judge				25b. REGISTRAR'S SIGNATURE
DATE AUG 12 1966												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 16 MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Talbot				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 28 AURORA STREET				d. STREET ADDRESS 28 AURORA ST				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Simon	Middle D.	Last HAWKINS	4. DATE OF DEATH Month 8 Day 15 Year 1966										
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11-11-1891		9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		11. IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) haboper				10b. KING OF BUSINESS OR INDUSTRY DOMESTIC				11. BIRTHPLACE (County & State, or foreign country) Talbot, Md				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Richard T. Hawkins				14. MOTHER'S MAIDEN NAME HENRIETTA MITCHELL											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 215-18-4845				17. INFORMANT HELEN HAWKINS		Address EASTON, Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE MYOCARDIAL INFARCTION												INTERVAL BETWEEN ONSET AND DEATH MINUTES			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b)				DUE TO ASCVD								YEARS			
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
p.m.															
21. I certify that I (this hospital) attended the deceased from 7-10 , 19 65 to 8-15 , 19 66 , that I (we) last saw the deceased alive on 8-15 19 66 and that death occurred at 3A M, from the causes and on the date stated above.															
22a. SIGNATURE R.F. Tyson								22b. DATE SIGNED 8-19-66							
22c. PHYSICIAN'S NAME (Type) RICHARD F. TYSON				22d. ADDRESS 36 S. AURORA ST.				23d. LOCATION (City, town or county) Talbot, Md				(State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8-19-66				23c. NAME OF CEMETERY OR CREMATORIAL Richard's Cemetery				23d. LOCATION (City, town or county) EASTON, Md			
24. FUNERAL DIRECTOR James B. Nashel				ADDRESS EASTON, Md				25a. REG'D BY REGISTRAR Charles Judge				25b. REGISTRAR'S SIGNATURE			
								DATE AUG 18 1966							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

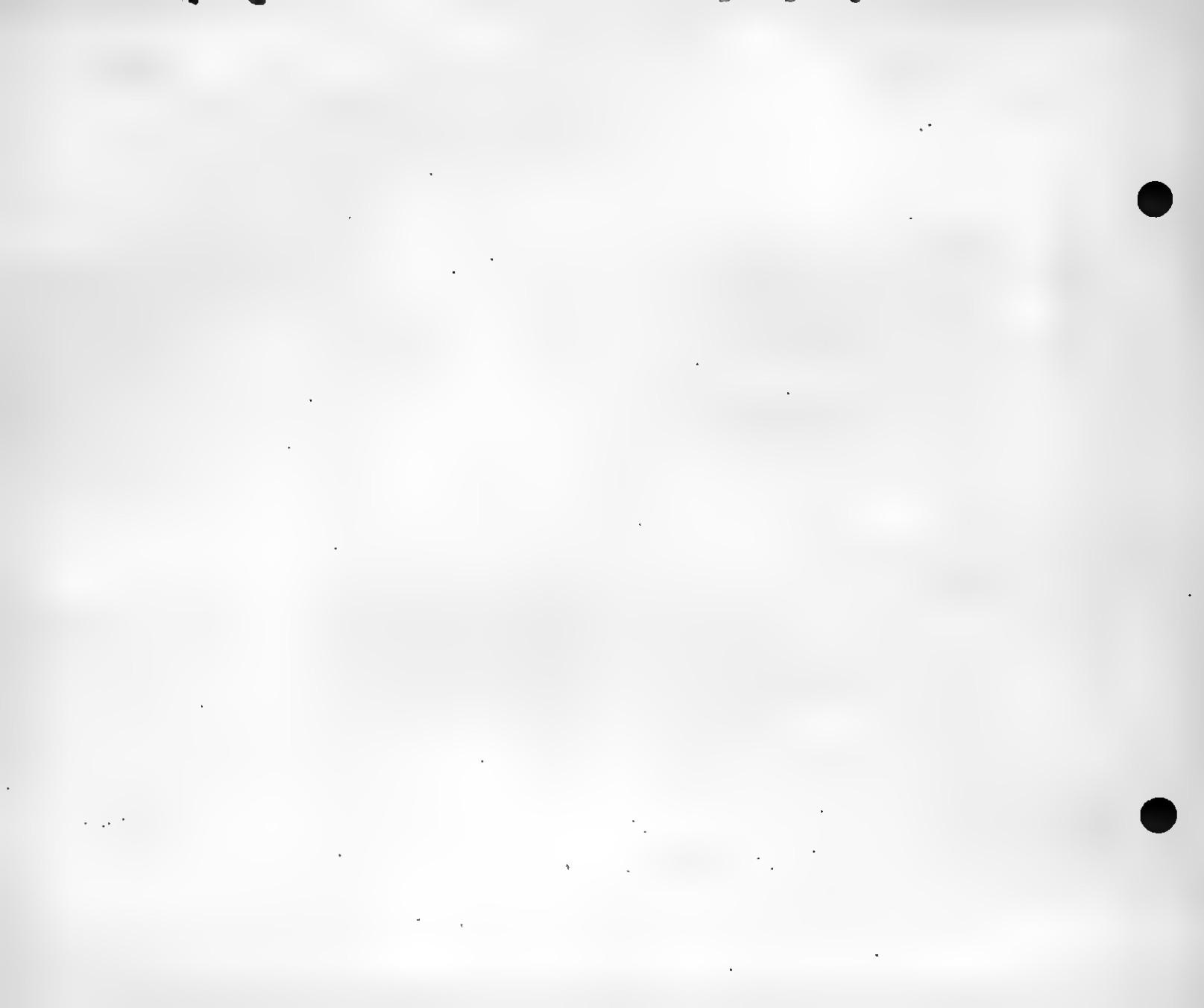
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11899

11895

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL EASTON		c. LENGTH OF STAY IN 1b 10 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BAILEY'S NECK ROAD		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL EASTON	
3. NAME OF DECEASED (Type or print)	First MARCIA	Middle GRUMES	Last HERSLOFF
4. DATE OF DEATH August 23 1966	Month August	Day 23	Year 1966
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 1, 1897
9. IF UNDER 1 YEAR Months 6	10. IF UNDER 24 HRS. Months 9	11. BIRTHPLACE (County & State, or foreign country) ORANGE, NEW JERSEY	12. CITIZEN OF WHAT COUNTRY U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	13. FATHER'S NAME ARTHUR J. GRUMES	
14. MOTHER'S MAIDEN NAME LAURA FOREMAN	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) <input type="checkbox"/> (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.	17. INFORMANT PETER O. HERSLOFF EASTON - MD.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Pneumonia			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1810			
DUE TO (b) Carcinoma of the bladder			
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (c)			
DUE TO (b) 10 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dutchman's Lane, Easton, Md.
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec 1965 to 23 Aug 1966 , that (I) (we) last saw the deceased alive on 23 Aug 1966 , and that death occurred at 2 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Stephen P. Carney			
22b. DATE SIGNED 8-23-66			
22c. PHYSICIAN'S NAME (Type) Stephen P. Carney, M.D.		22d. ADDRESS Dutchman's Lane, Easton, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) CREMATION		23b. DATE THEREOF August 23 1966	
23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL		23d. LOCATION (City, town or county) (State) WASHINGTON D.C.	
24. FUNERAL DIRECTOR John G. Charles Jr.		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Charles Jr.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE AUG 25 1966			



1

M

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

11896

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Jalbot		b. STATE D. COUNTY	
MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
7 days		GRASONVILLE	
c. LENGTH OF STAY IN 1D		d. STREET ADDRESS	
7 days			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
f. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			
Memorial Hospital			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
Charles E. Horney		Aug 29 1966	
First Middle Last		Month Day Year	
5. SEX		6. COLOR OR RACE	
MALE		WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		JUNE 16-1893	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
73 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
WATERMAN		11. BIRTHPLACE (County & State, or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
USA		JOHN Horney	
14. MOTHER'S MAIDEN NAME		UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
ROBERT HORNEY		Chester MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thremia		Unknown	
DUE TO { Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Chronic pyelonephritis and	
DUE TO { (c)		nephrosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Unknown	
Arteriosclerotic heart disease. Gout. Prostatic hypertrophy.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8-22, 1966, to 8-29, 1966, that (I) (we) last saw the deceased alive on 8-29, 1966, and that death occurred at 10:45 M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE		8-29-66	
Robert W. Trevor		P	
22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
ROBERT W. TREVER		EASTON MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
BURIAL		SEPT 1	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) (State)	
Woodlawn		EASTON MD.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
Edgar L. Lane Church Hill Md.		25b. REGISTRAR'S SIGNATURE	
DATE SEP 6 1966		j. carles judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

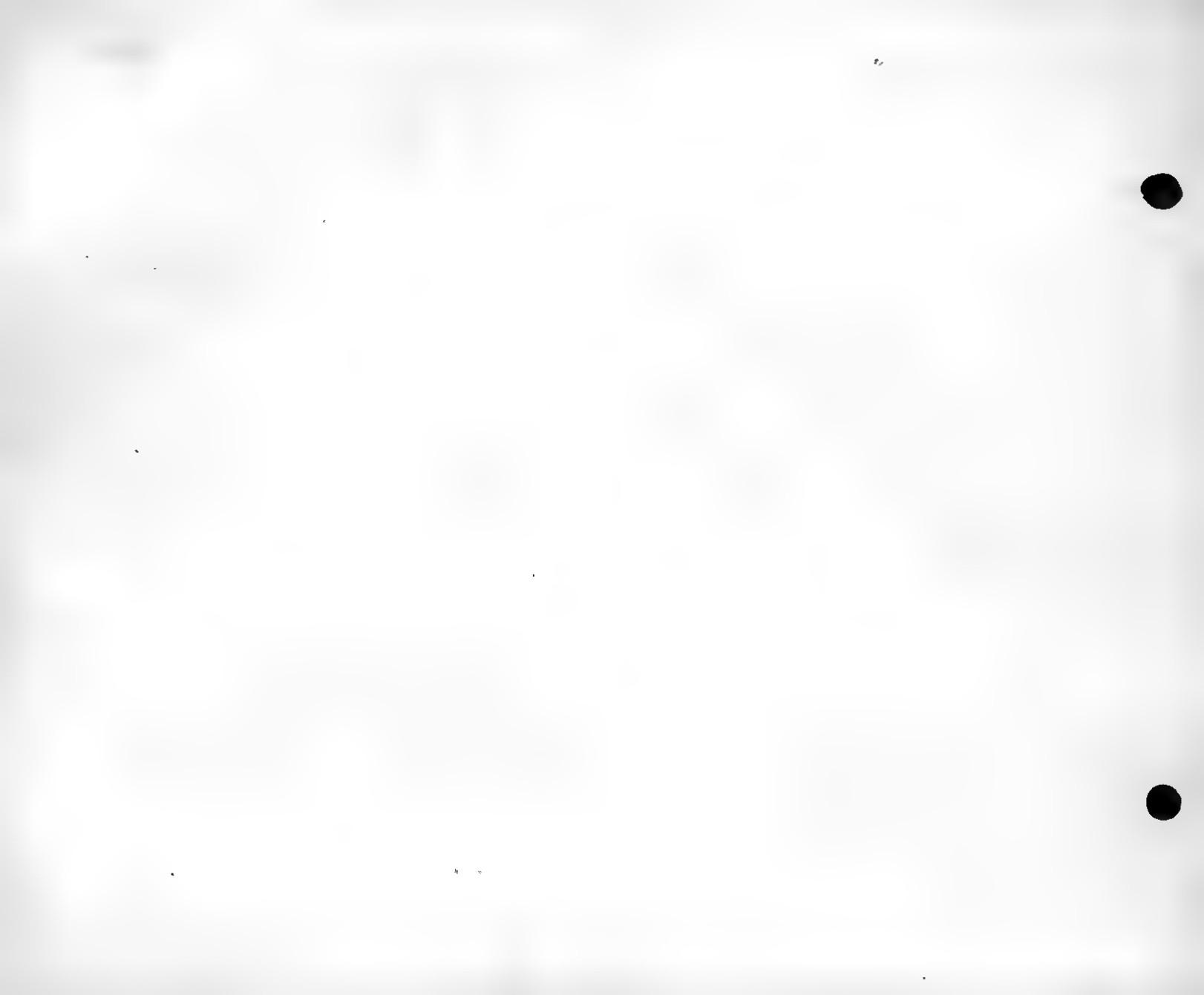
NO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11907

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11897

1 PLACE OF DEATH a COUNTY		MARYLAND		2 USUAL RESIDENCE (Where deceased resided, if institution Reside before admission)	
Talbot				b. STATE MD	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FASTON		c LENGTH OF STAY IN lb. D.O.A. 5pm		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FASTON	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d STREET ADDRESS 418 SOUTH STREET		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)		First VIRGINIA	Middle E	Last HOWARD	Month OUG
S SEX FEMALE		6 COLOR OR RACE <input checked="" type="checkbox"/> NEGRO	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/30/06
9 AGE (in years last birthday) 50 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME CHARLES HOWARD		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes give war or dates of serv ce) No		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address EASTON, MD	
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Bleeding pericardium		INTERVAL BETWEEN ONSET AND DEATH sudden	
(b) DUE TO		Ruptured aorta		sudden	
(c) DUE TO		Med. ad. adrenocystic cystica		(31)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County)				(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Thurston Harrison		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				Address (Street, city, town, or county)	
22. DATE SIGNED 9 Aug 66					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-11-66		23c. NAME OF CEMETERY OR CREMATORIAL Richards MEMORIAL	
24. FUNERAL DIRECTOR James B Dashiel Esq for md		ADDRESS		23d. LOCATION (City or Town) Easton Talbot Md	
				(Country) (State)	
				25a. REC'D BY REGISTRAR DATE AUG 15 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11902

CERTIFICATE OF DEATH

11898

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN lb <i>3 days</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Talbot</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <i>None</i>		e. DATE OF DEATH Month <i>8</i>		Day Year <i>31 1966</i>									
3. NAME OF DECEASED (Type or print)	First <i>Mrs. Freda</i>	Middle <i>Ellen</i>	Last <i>Hubbard</i>	4. DATE OF DEATH Month <i>May 15</i>	Year <i>1915</i>	5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Month <i>May 15</i>	9. AGE (in years last birthday) yrs. <i>51</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Grocery Store</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>William Price</i>	14. MOTHER'S MAIDEN NAME <i>Etta Dyer</i>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <i>213-01-7084</i>		17. INFORMANT <i>Ralph Hubbard</i>		Address <i>Greensboro, Md.</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH <i>8-30-66</i>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> DUE TO <i>Cerebral arteriosclerosis and</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Shock and paroxysmal atrial</i> DUE TO <i>acute myocardial infarction</i> (c) <i>Diabetes mellitus & ketoacidosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Acute myocardial infarction</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>While at work</i>								20c. TIME OF INJURY Month, Day, Year Hour a.m. D.M. <i>19</i>		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Easton</i>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8-29</i> , 19 <i>66</i> , to <i>8-31</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8-31</i> 19 <i>66</i> , and that death occurred at <i>11 p.m.</i> from the causes and on the date stated above.		22a. SIGNATURE <i>Robert W. Trever</i>		22b. DATE SIGNED <i>9/1/66</i>		22c. PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i>		22d. ADDRESS <i>M.D. Easton, Maryland</i>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/>		22f. MED. DIRECTOR <input type="checkbox"/>		22g. STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9-4-66</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Greenstoro</i>		23d. LOCATION (City, town or county) <i>Greensboro, Md.</i>		(State)									
24. FUNERAL DIRECTOR <i>J. E. Boulaus</i>		ADDRESS <i>Greensboro, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 6 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11903
CERTIFICATE OF DEATH

11899

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>	b. COUNTY <i>Talbot</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wittman</i>	c. LENGTH OF STAY IN 1b <i>Lifetime</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wittman</i>	d. STREET ADDRESS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Louise J. Knox</i>	First	Middle	Last	4. DATE OF DEATH <i>August 3 1966</i>	Month	Day	Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/1/1907</i>	9. AGE (In years at birthday) <i>58 yrs.</i>	10. IF UNDER 1 YEAR Months <i>58</i>	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Talbot Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>William P. Brandom</i>	14. MOTHER'S MAIDEN NAME <i>Ada May Jackson</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Lloyd Knox, Wittman, Maryland</i>	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> (c) <i>Arteriosclerosis of Sigmoid Colon</i>					INTERVAL BETWEEN ONSET AND DEATH <i>8 mos</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>April 19 1966</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <i>19 1966</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>St. Michaels, Maryland</i>	20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>April 19 1966</i> to <i>Aug 3 1966</i> , that (I) (we) last saw the deceased alive on <i>Aug 2 1966</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.					22b. DATE SIGNED <i>8-4-66</i>			
22a. SIGNATURE <i>R. Lane Wroth</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <i>R. Lane Wroth</i>	22d. ADDRESS <i>St. Michaels, Maryland</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>8/6/1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Olivet</i>	23d. LOCATION (City, town or county) (State) <i>St. Michaels, Md.</i>					
25a. REC'D BY REGISTRAR <i>By J. Lee & Moore, Jr. & Son, Inc.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						
DATE AUG 10 1966								
VR A15 (4) 20M 1/65								



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Cambridge</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN 1b <i>42 da.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Matthew</i>	Middle <i>Bartlett</i>	Last <i>LeCompte</i>
4. DATE OF DEATH 8 23 1966	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1892
9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Centreville, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph M. Bartlett	14. MOTHER'S MAIDEN NAME Mary Cannon	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Mrs. C. Tilghman Bishop, Centreville, Md.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of liver</i>		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of breast</i> (c)		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from July 1955 , to 23 Aug 1966 , that (I) (we) last saw the deceased alive on 23 Aug 1966 , and that death occurred at Cambridge, Maryland , from the causes and on the date stated above.			
22a. SIGNATURE <i>Thorston Harrison</i>		22b. DATE SIGNED 24 Aug 66	
22c. PHYSICIAN'S NAME (Type) THORSTON HARRISON		22d. ADDRESS Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 25, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Christ P.E. Churchyard	23d. LOCATION (City, town or county) Cambridge, Maryland (State)
24. FUNERAL DIRECTOR <i>LeCompte, F. H. Cambridge, Md.</i>	ADDRESS	25a. REC'D BY REGISTRAR AUG 26 1966	25b. REGISTRAR'S SIGNATURE <i>Charles J... J... J...</i>



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

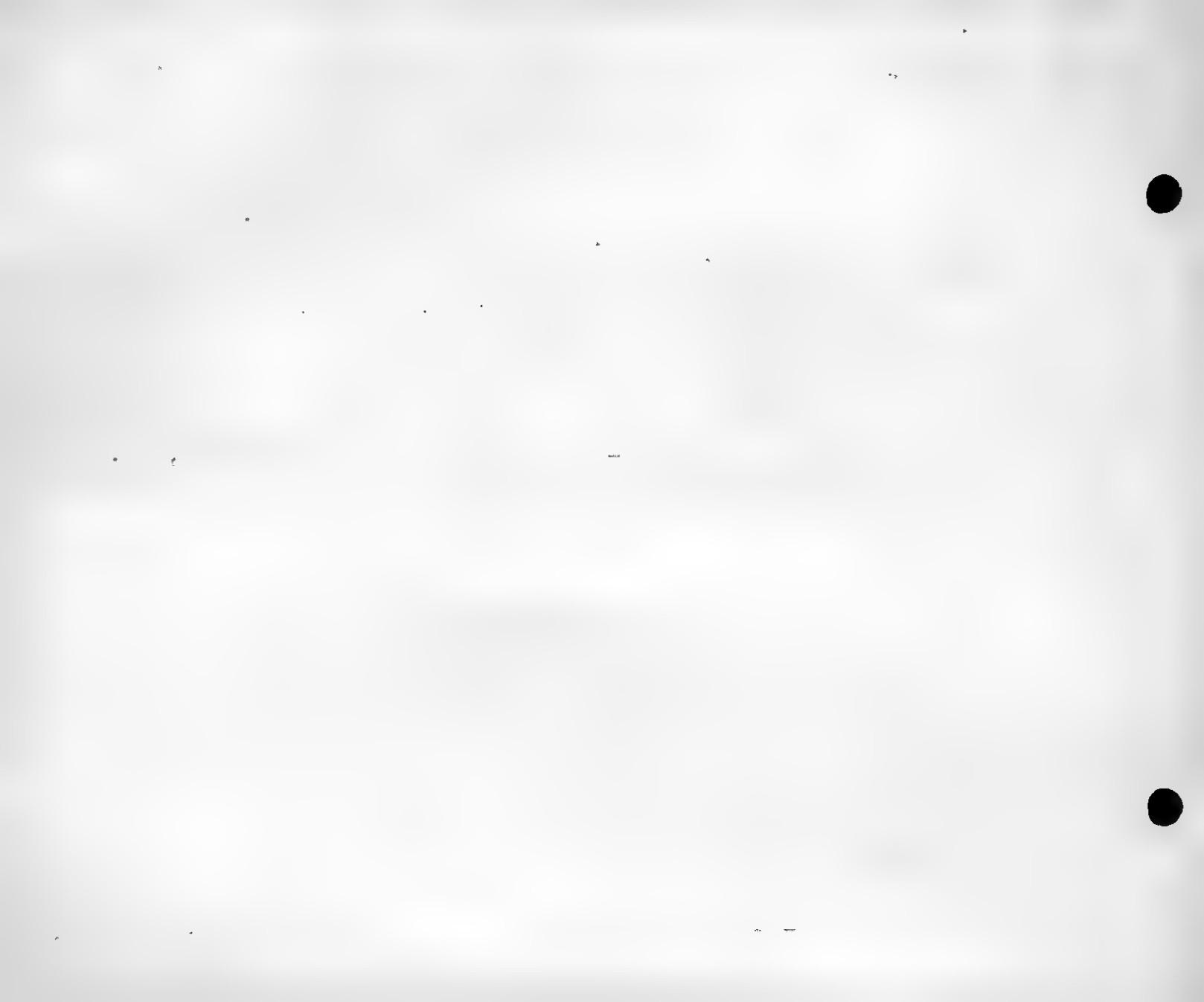
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit if the event within 72 hours after death. Death or its designated agent, prior to burial, cremation, or removal, or

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 955 Rue 13270

1 PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ridgely</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Carey Memorial</i>		d. STREET ADDRESS <i>412 Central Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) <i>Theodore McFan Manship</i>		First	Middle	4. LOST	5. DATE OF DEATH <i>8</i>	Month <i>3</i>	Day <i>19</i>	Year <i>66</i>
6. SEX <i>M</i>	7. COLOR OR RACE <i>W</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D-VORCED	9. DATE OF BIRTH <i>11-8-41</i>	10. AGE (In years at birthday) <i>24</i>	11. IF UNDER 1 YEAR Months <i>0</i>	12. IF UNDER 24 HRS Days <i>0</i>	13. Day <i>0</i>	14. Year <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most time working, to avoid fractures) <i>Machine Operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DuPont Co</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>		
13. FATHER'S NAME <i>Theodore Manship</i>		14. MOTHER'S MAIDEN NAME <i>Agnes Royer</i>		15. INFORMANT <i>Veronica Manship Ridgely, Md.</i>		Address		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) <i>No</i>		17. SOCIAL SECURITY NO <i>212-40-7597</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Multiple fractures of the skull</i> DUE TO <i>8214</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Su dural hemorrhage</i> (b) <i>45 min</i> DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH <i>1 hour 45 minutes</i>		
20. MEDICAL CERTIFICATION PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		22. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Thrown from a Honda on 312 route no 'th of Ridgely</i>		23. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>Md</i>		
20a. TIME OF INJURY Month, Day, Year hour am <i>9:10 p 8/40 1966</i>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <i>Route 312</i>		20c. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <i>Ridgely, Maryland</i>		20d. (City or town) <i>Jeanine</i>		(State) <i>Md</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> <i>Actual Signature: B. Plummer</i>		22. DATE SIGNED <i>8/6/66</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) <i>Baltimore, Maryland</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9-2-66</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Holy Cross</i>		23d. LOCATION (City or Town) <i>Near Greensboro</i>		(County) <i>Md.</i>
24. FUNERAL DIRECTOR <i>J. E. Boulaire Greensboro, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE		
VR A15ME 6M 1/66		DATE <i>SEP 8 1966</i>						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11906

CERTIFICATE OF DEATH

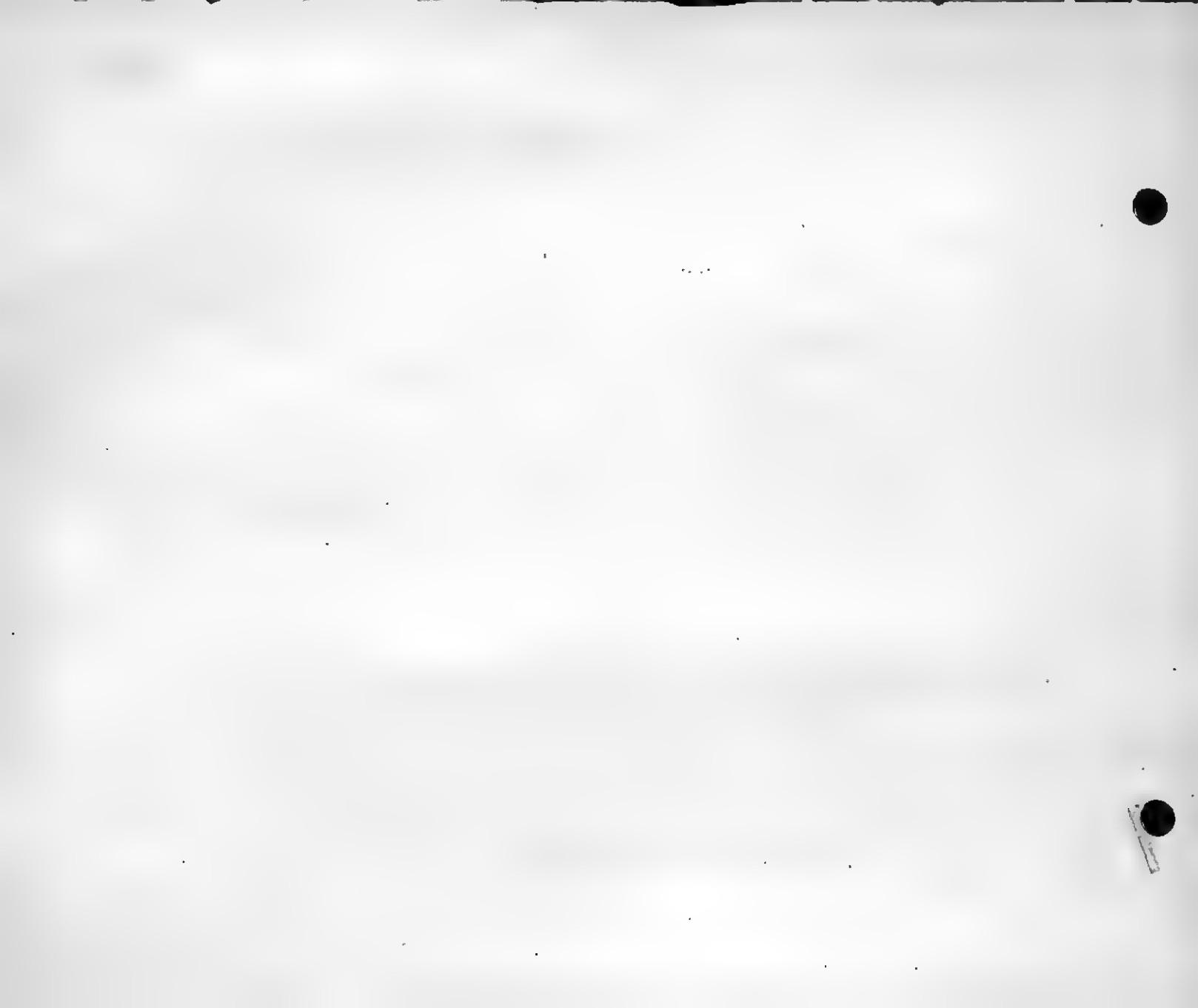
11901

be executed within 24 hours after death.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Item 9 Form 6360 1/5/66 mm		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
<i>Talbot</i>		MARYLAND		a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1B <i>6 days</i>		b. COUNTY	
Cheston					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Memorial</i>					
3. NAME OF DECEASED (Type or print)	First <i>H. James</i>	Middle <i>Merle</i>	Last	4. DATE OF DEATH <i>8</i>	Month <i>Aug</i>
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH <i>70 Apr 1900</i>	9. AGE (In years last birthday) Months Days Hours Min. <i>70 Approx.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>42-1</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO					
<i>Acute congestive heart failure</i> <i>Cerebral thromboembolic C-V disease</i>					
INTERVAL BETWEEN ONSET AND DEATH (?)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Thalidomide</i>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that (I) (this hospital) attended the deceased from <i>16 Aug 1966</i> , to <i>22 Aug 1966</i> , that (I) (we) last saw the deceased alive on <i>22 Aug 1966</i> , and that death occurred at <i>44 M</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>Thurston Harrison</i>					
22b. DATE SIGNED <i>24 Aug 66</i>					
22c. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>		ATTENDING M.D. <input checked="" type="checkbox"/> PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
		22d. ADDRESS <i>Cheston, Maryland</i>			
23a. BURIAL CREMATION REMOVAL (Specify) <i>8.26.66</i>		23b. DATE THEREOF <i>8.26.66</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>S of Mt. Washington</i>	
				23d. LOCATION (City, town or county) <i>Baltimore, Md</i>	
24. FUNERAL DIRECTOR <i>Frampston Funeral Home Federally Inc.</i>		ADDRESS <i>100 W. Pratt Street</i>		25a. REG'D BY REGISTRAR <i>AUG 29 1966</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

11907

11902

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN IB <u>20A - 9 1/2 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>ST. MICHAELS</u>	
f. STREET ADDRESS <u>CHEW AVE.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <u>Raymond</u> Middle <u>Fred</u> Last <u>Minster</u>		4. DATE OF DEATH Month <u>8</u> Day <u>22</u> Year <u>1966</u>	
S. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 14, 1945</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poultry Feed</u>	
11. BIRTHPLACE (State or foreign country) <u>PHILA. PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD B. Minster</u>		14. MOTHER'S MAIDEN NAME <u>Anne Powderhill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-42-5282</u>	
		17. INFORMANT <u>Mrs. ANNE K. Phillips, St. Michaels, Md.</u>	
Address		INTERVAL BETWEEN DEATH AND AUTOPSY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured skull</u>		INTERVAL BETWEEN DEATH AND AUTOPSY	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO (b) <u>Fall from silo</u>			
DUE TO (c) <u></u>			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) <u>Fall from grain silo</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> pm <u>8-22</u> <u>1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street offce bldg, etc.) <u>MILL</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		20f. (City or town) <u>EASTON</u> (County) <u>TAL</u> (State) <u>MD</u>	
ACTUAL SIGNATURE <u>Lewis O. Welty</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WELTY</u>		MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>8-27-66</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town or county)			
23a. BUR AL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Aug 24, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORIUM <u>SPRING HILL CEMETERY</u>		23d. LOCATION (City or Town) <u>EASTON, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>Hamperton Harrison, St. Michael's</u>		ADDRESS	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 25 1966</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11508

CERTIFICATE OF DEATH

11903

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
TALBOT		a. STATE	b. COUNTY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1B	
Easton		c. LENGTH OF STAY IN 1B 1 hr 10 min	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
Memorial Hospital		204 Dukes Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Fredrick		C.	Mueller
4. DATE OF DEATH	Month	Day	Year
	8	12	1966
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3/29/1893
9. AGE (In years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
73 yrs.	Farming	Cass Iowa	USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Frederick W. Mueller	Wilhelminia Ostermann		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	220-28-0746	Mrs. Fred C. Mueller, Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive retroperitoneal hemorrhage			
INTERVAL BETWEEN ONSET AND DEATH			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of left iliac artery			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (We) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE E. C. H. Schmidt		22c. PHYSICIAN'S NAME (Type) F. C. H. Schmidt	
22d. ADDRESS Easton Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 8/15/1966		23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill	
24. FUNERAL DIRECTOR Maurice F. Newman-Son		23d. LOCATION (City, town or county) (State) Easton, Md.	
ADDRESS		25a. REC'D BY REGISTRAR AUG 16 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)											
Talbot, Maryland			Maryland			11901											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			d. STREET ADDRESS											
Talbot			6 days			44 10th & 4th Street											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year								
Sister - E. L. K. Nixon						July 17	1966	8	1	19							
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	19. WAS AUTOPSY PERFORMED? (Yes <input type="checkbox"/> No <input type="checkbox"/>)		
Male		White	WIDOWED <input checked="" type="checkbox"/>	July 17 1911	76 yrs.	INDUSTRY	Talbot, Md.	Talbot, Md.	Timothy Nixon	Ermeline Nixon	No			Myocardial Infarction	INTERVAL BETWEEN ONSET AND DEATH Hours		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO (b)		DUE TO (c)		ASCVD		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								4.201	Yellus
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
19																	
21. I certify that (I) this hospital attended the deceased from 8-1, 1966, to 8-1, 1966, that (I) (we) last saw the deceased alive on 8-1, 1966, and that death occurred at 3A.M., from the causes and on the date stated above.																	
22a. SIGNATURE		22b. DATE SIGNED 8-2-66															
22c. PHYSICIAN'S NAME (Type)		Richard F. Tyson M.D.															
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county)		(State)									
Burial		Aug 5, 1966		Baptist Cemetery		Talbot, Md.											
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Charles J. DeLoach		Talbot, Md.				AUG 11 1966		Charles Judge									
VR A15 (4) 20M 1/65																	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 230 film 559 8/11/66 mh MEDICAL EXAMINER'S CERTIFICATE OF DEATH												11905
1 PLACE OF DEATH a. COUNTY <i>Talbot</i>				2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before adm ssion) a. STATE <i>MARYLAND</i> b. COUNTY <i>CHESTERFIELD</i>								
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>EASTON</i>				c LENGTH OF STAY IN b <i>D.O.A.</i>				c CITY OR TOWN (If out of corporate limts, write RJRAL and give nearest town) <i>RURAL</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>				d STREET ADDRESS <i>3005 PARKDALE ROAD</i>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print)		First <i>Winfred</i>	Middle <i>Irvin</i>	Last <i>Perkinson</i>	4 DATE OF DEATH <i>8-3-1966</i>	Month <i>8</i>	Day <i>3</i>	Year <i>1966</i>				
5 SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH <i>JULY 28, 1929</i>	9. AGE (in years from birthdate) <i>37 yrs</i>	10. IF UNDER 1 YEAR <i>0 months</i>	11. IF UNDER 24 HRS <i>1 days</i>	12. IF UNDER 24 HRS <i>0 hours</i>	13. FATHER'S NAME <i>TRUCK DRIVER</i>	14. MOTHER'S MAIDEN NAME <i>MINOR MULCHI</i>	15. BIRTHPLACE (State or foreign country) <i>NORTH CAROLINA</i>	16. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10. DO U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TRUCK DRIVER</i>				11b. KIND OF BUSINESS OR INDUSTRY <i>PRESTON MD. TRUCKING</i>				12. ADDRESS <i>3005 PARKDALE RD. RICHMOND, VA.</i>				
13. FATHER'S NAME <i>TURNER IRVIN PERKINSON</i>				14. MOTHER'S MAIDEN NAME <i>LUCILLE EDMONDS PERKINSON</i>				15. INTERVAL BETWEEN ONSET AND DEATH <i>SECONDS</i>				
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Fractured occipital region of skull</i>				17. INFORMANT <i>Address</i>				18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>10</i>				19. DUE TO (b) <i>Fractures cervical vertebrae</i> (c) <i>Automobile accident</i>				20. DUE TO <i>seconds</i>				
21. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Toxicology reports will follow if significant</i>				22. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>recreational out of control - Jack-knifed trucking driver</i>				23. TIME OF INJURY Month, Day, Year <i>140 p.m. 8-3-1966</i>				
24. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>R1 313</i>				26. (City or town) <i>Reston</i> (County) <i>Cyberline</i> (State) <i>VA.</i>				
27. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				28. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Harold B. Plummer MD				29. DATE SIGNED <i>8/16/66</i>				
ACTUAL SIGNATURE <i>Harold B. Plummer</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <i>Harold B. Plummer M.D.</i>				Address (Street, city, town, or county)								
30. BURIAL, CREMATION, REMOVAL (Specify)		31. DATE THEREOF <i>Aug. 5, 1966</i>		32. NAME OF CEMETERY OR CREMATORIAL <i>SUNSET MEMORIAL PARK</i>		33. LOCATION (City or Town) <i>CHESTER</i>		(County) <i>VA.</i>		(State)		
34. FUNERAL DIRECTOR <i>Kelley</i>		ADDRESS <i>Bethel St. N.E.</i>		35. REC'D BY REGISTRAR <i>AUG 8 1966</i>		36. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



1 M

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

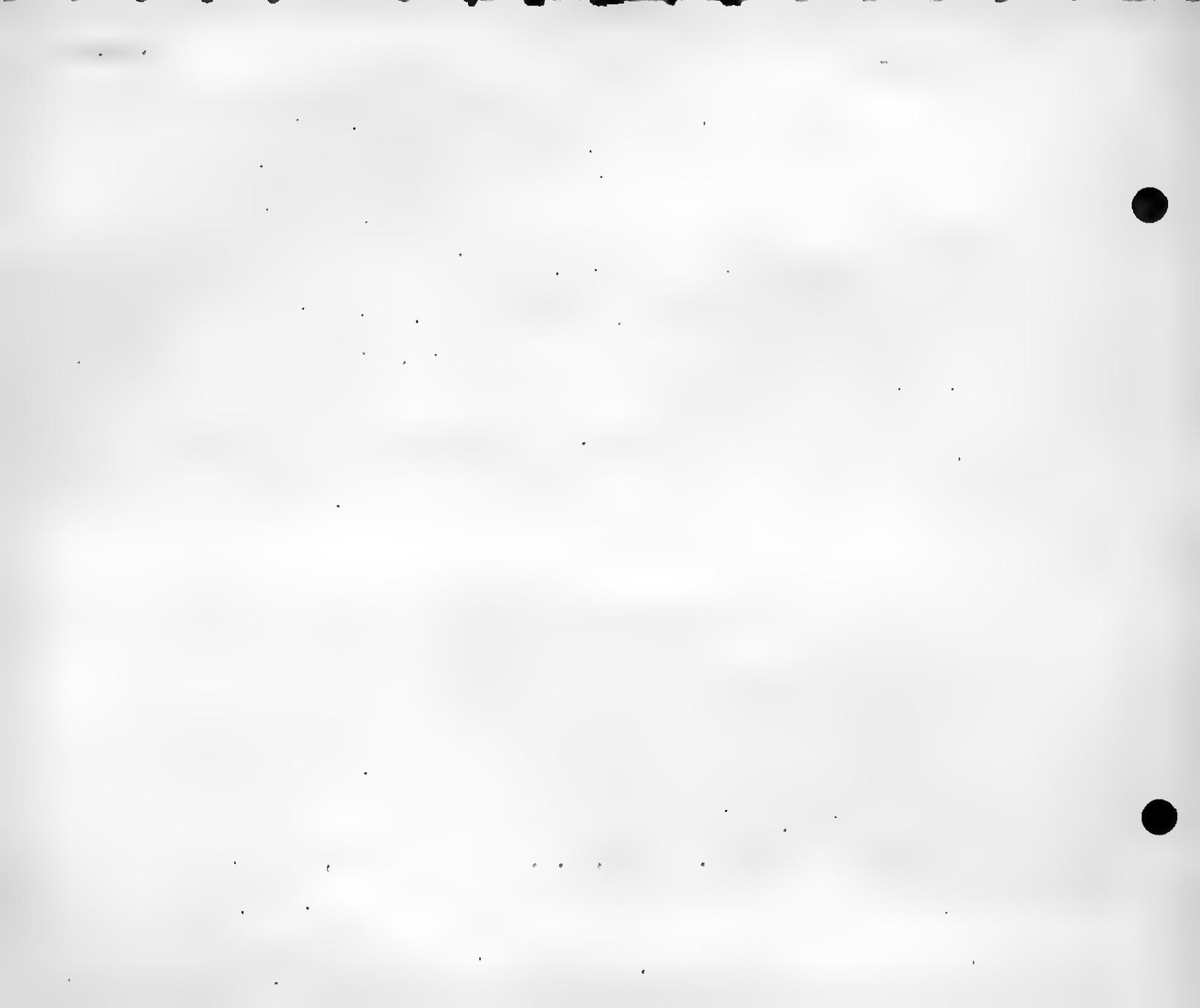
11S11

11906

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
J. Talbot MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Easton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS Rt. #1, Box 192	
c. LENGTH OF STAY IN 1D 2 days		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp.		f. DATE OF DEATH 8 25 1966	
3. NAME OF DECEASED (Type or print) Daisy Virginia Plummer		First	Middle
Last		4. DATE OF DEATH 8 25 1966	Month Day Year
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. ODE OF BIRTH Sept. 5, 1882		9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (County & State, or foreign country) Cecil, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Gus Conrad		14. MOTHER'S MAIDEN NAME Susie Kissinger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-44-1844	
17. INFORMANT		Address Miss Dorothy Plummer Rt. #1, Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO DUE TO DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
19		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 22 ay, 1965 to 25 ay, 1966, that (I) (we) last saw the deceased alive on 8/25 1966, and that death occurred at 634 M, from the causes and on the date stated above.			
22a. SIGNATURE Stephen P. Carney		22b. DATE SIGNED 8-26-66	
22c. PHYSICIAN'S NAME (Type) Stephen P. Carney, M.D.		22d. ADDRESS Easton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Talbot		23b. DATE THEREOF Aug. 29, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery		23d. LOCATION (City, town or county) Easton, Maryland (State)	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR Charles Judge	
Maurice E. Neumann, Jr.		25b. REGISTRAR'S SIGNATURE DATE AUG 30 1966	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11912

CERTIFICATE OF DEATH

11907

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Dorchester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>1 1/2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hurlock - Rural</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <i>Near Williamsburg</i>			
3. NAME OF DECEASED (Type or print)	First <i>Roland</i>	Middle <i>Roland</i>	Last <i>Seth</i>	4. DATE OF DEATH Month <i>8</i> Day <i>6</i> Year <i>1966</i>	Month <i>8</i>	Day <i>6</i>	Year <i>1966</i>
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1894	9. AGE (In years last birthday) 72 yrs.	10. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming				
13. FATHER'S NAME Robert S. Poole			14. MOTHER'S MAIDEN NAME Malinda Wright				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO. 215-36-1630		17. INFORMANT Mrs. Lula Poole, Hurlock, Md. RFD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Cerebral hemorrhage in Right hemisphere							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO hemiplegia (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 48 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 9, 1966 , to Aug. 10, 1966 , that (I) (we) last saw the deceased alive on Aug. 9, 1966 , and that death occurred at 6:30 AM , from the causes and on the date stated above.		22b. DATE SIGNED Aug. 11, 1966					
22a. SIGNATURE <i>Thurston Harrison</i>		22b. DATE SIGNED Aug. 11, 1966					
22c. PHYSICIAN'S NAME (Type) Thurston Harrison, M. D.		22d. ADDRESS Caston, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 9, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		23d. LOCATION (City, town or county) (State) Federalsburg, Maryland	
24. FUNERAL DIRECTOR <i>J. J. Frayton & Son, Federalsburg, Md.</i>		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
ADDRESS		DATE AUG 11 1966					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11913

CERTIFICATE OF DEATH

11908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
TALBOT		a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1D RURAL EASTON 5 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
R.D+I Box 338			
3. NAME OF DECEASED (Type or print)	First Ray	Middle ALLEN	Last PORTER
4. DATE OF DEATH	Month 8	Day 3	Year 1966
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 23 1887
9. AGE (in years (last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS. Days 6	12. Hours 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN	10b. KIND OF BUSINESS OR INDUSTRY ELECTRICAL	11. BIRTHPLACE (County & State, or foreign country) CECIL, MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Wm ROBERT PORTER	14. MOTHER'S MATURE NAME RACHEL Montgomery	Address NORTH BEND EASTON MD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 221-09-7134	17. INFORMANT MRS R.A. PORTER	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Instant	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Ventricular arrhythmia DUE TO (c) Arteriosclerotic heart disease about 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5 mo , 19 65 , to 3 Aug , 19 66 , that (I) (we) last saw the deceased alive on 27 May 19 66 , and that death occurred at 1227 M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Stephen C. Carney</i>		22b. DATE SIGNED 3 Aug 66	
22c. PHYSICIAN'S NAME (Type)		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) 8-6-66		23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Memorial	23d. LOCATION (City, town or county) EASTON MD
24. FUNERAL DIRECTOR <i>Robert Clark</i>		25a. ADDRESS Easton, Md.	25b. REC'D BY REGISTRAR DATE AUG 8 1966 REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>

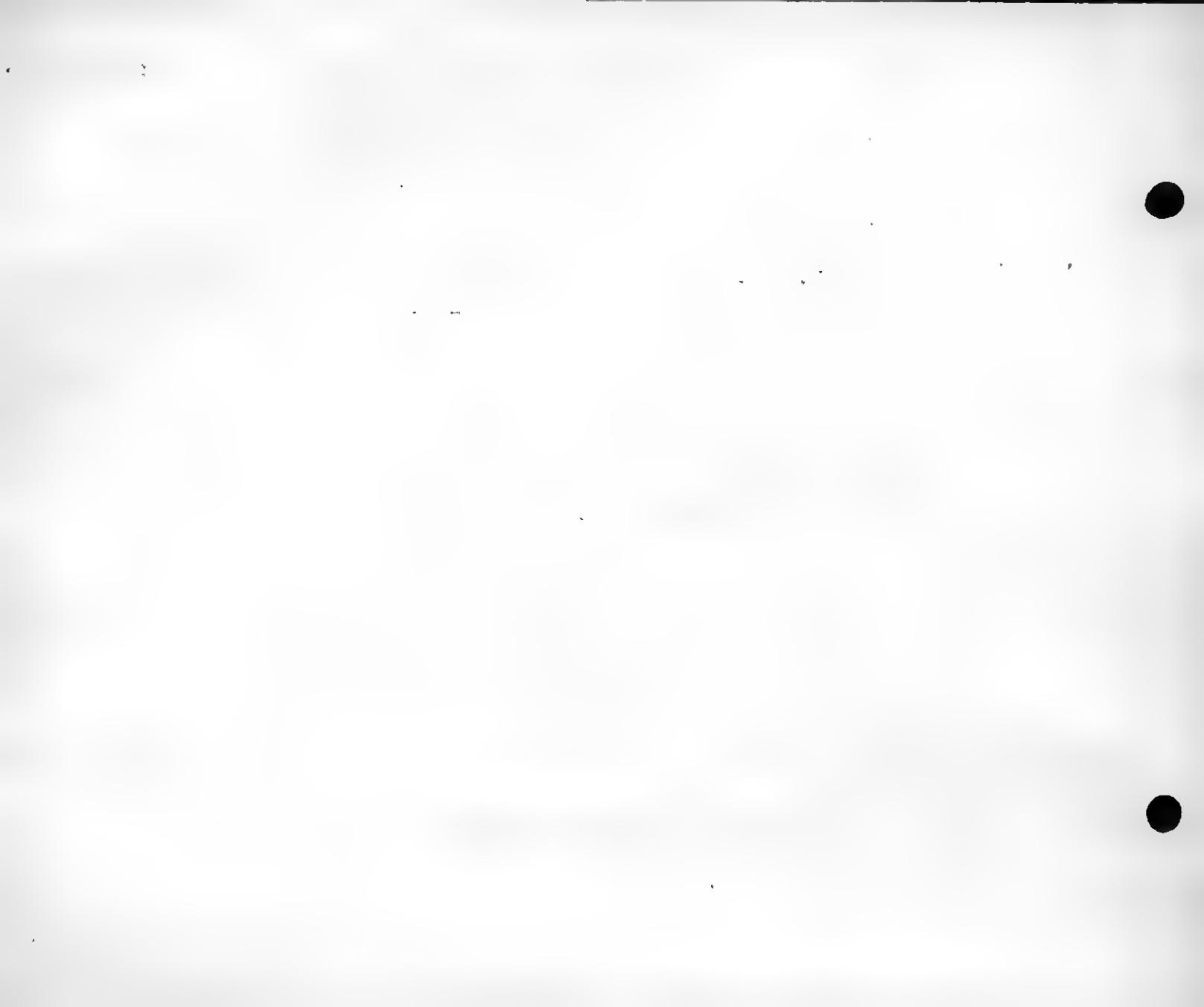


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If 24 hr delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Items #11, 12, 13, & 23, 1, 5 & d Film 7-330 1/20 3 pc											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
11914 11909											
1 PLACE OF DEATH a. COUNTY Talbot MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Caroline					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton			c. LENGTH OF STAY IN 1b 2 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital						d. STREET ADDRESS					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First Lottie M.		Middle Robertson		4. DATE OF DEATH Aug 15 1966		Month Year		Day Year	
S. SEX f	6. COLOR OR RACE w	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 7-18-82	C. AGE (in years last birthday) 84 yrs	F. UNDER 1 YEAR Months 0	F. UNDER 24 HRS Days 0	H. UNDER 1 YEAR Hours 0	I. UNDER 24 HRS Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) White Haven, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Henry Robertson						14. MOTHER'S MAIDEN NAME Charlotte White					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Kyphosclerotic cardiac disease INTERVAL BETWEEN ONSET AND DEATH years 4200											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			DUE TO (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
Severe anemia			Fractured hip						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B) fell in bath room			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> home		
20e. (City or town) Denton (County) Car (State) Md											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Harold B. Plummer</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) Harold B. Plummer									Address (Street, city, town, or county) Tyaskin, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/18/66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS CIA Messick Bivalve Md.			23d. LOCATION (City or Town) (County) (State) Tyaskin, Maryland				
24. FUNERAL DIRECTOR CIA Messick Bivalve Md.		25. REG'D BY REGISTRAR DATE AUG 18 1956			25. REGISTRAR SIGNATURE Charles Judge						



1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11915

CERTIFICATE OF DEATH

11910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
<i>Talbot</i>		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>EASTON</i> 12 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MEMORIAL HOSPITAL</i>	
3. NAME OF DECEASED (Type or print)		First <i>John</i>	Middle <i>Thomas</i>
3. NAME OF DECEASED (Type or print)		Last <i>SALISBURY</i>	4. DATE OF DEATH Month <i>8</i> Day <i>10</i> Year <i>1966</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>12-16-86</i>		9. AGE (In years last birthday) <i>79 yrs.</i>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CARETAKER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CHURCH PROP.</i>	11. BIRTHPLACE (County & State, or foreign country) <i>TALBOT MD</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>JOHN T. SALISBURY</i>		14. MOTHER'S MAIDEN NAME <i>JOSEPHINE BERRIDGE</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>716-09-6183</i>	17. INFORMANT <i>THIS. V. SALISBURY P.D. EASTON</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address <i>OAKLANDS</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 day</i>	
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>hypocardial infarction</i>		12 day	
DUE TO (c) <i>atherosclerotic coronary thrombosis</i>		12 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>January 10, 1966</i> , to <i>Aug 10, 1966</i> , that (I) (we) last saw the deceased alive on <i>10 Aug 1966</i> , and that death occurred at <i>Easton</i> M, from the causes and on the date stated above.		22b. DATE SIGNED <i>11 Aug 66</i>	
22a. SIGNATURE <i>Thurman Harrison</i>		ATTENDING M.O. PHYS. <input checked="" type="checkbox"/>	MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>HURSTON HARRISON</i>		22d. ADDRESS <i>Castor, Maryland</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>8-13-66</i>		23b. DATE THEREOF <i>8-13-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Springfield Cemetery</i>
24. FUNERAL DIRECTOR <i>Marie Black</i>		ADDRESS <i>Easton, Md</i>	25a. REC'D BY REGISTRAR <i>AUG 15 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11S15

11911

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				
Talbot		Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY				
L. EASTON	14 days	Talbot				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
Memorial Hospital		Tilghman				
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First	Middle	Last			
Female	Angie	E	Sinclair			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDERScore 1YEAR IF UNDER 24 HRS. Months Days Hours Min.	
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2/9/1886	80 yrs.	8 23 1966	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		
Housework				Talbot Maryland		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		
George W. Frampton		Angie L. Gibson		USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT		
		217-16-9169		Charles Sinclair, Tilghman, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cochlearia - severe - 6 mos				
4221 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		OUE TO (b)	other cerebro-vascular			
		DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Diabetes M. advanced senile changes		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)	20f. (City or town)	(County)	(State)
19						
21. I certify that (I) (this hospital) attended the deceased from 1959, 19 to 8-23, 1966 that (I) (we) last saw the deceased alive on 8-22, 1966 and that death occurred at 8:30 A.M. from the causes and on the date stated above.						22b. DATE SIGNED 8-23-66
22a. SIGNATURE Mary M. Reeser		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 8-23-66
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS St. Michael's Md				
Burial		23b. DATE THEREOF 8/26/1966	23c. NAME OF CEMETERY OR CREMATORIAL Methodist Cemetery	23d. LOCATION (City, town or county) Tilghman, Md.		
24. FUNERAL DIRECTOR Maurice E. Newnam & Son		ADDRESS EASTON, Md	25a. REC'D BY REGISTRAR DATE AUG 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



1 M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11S17

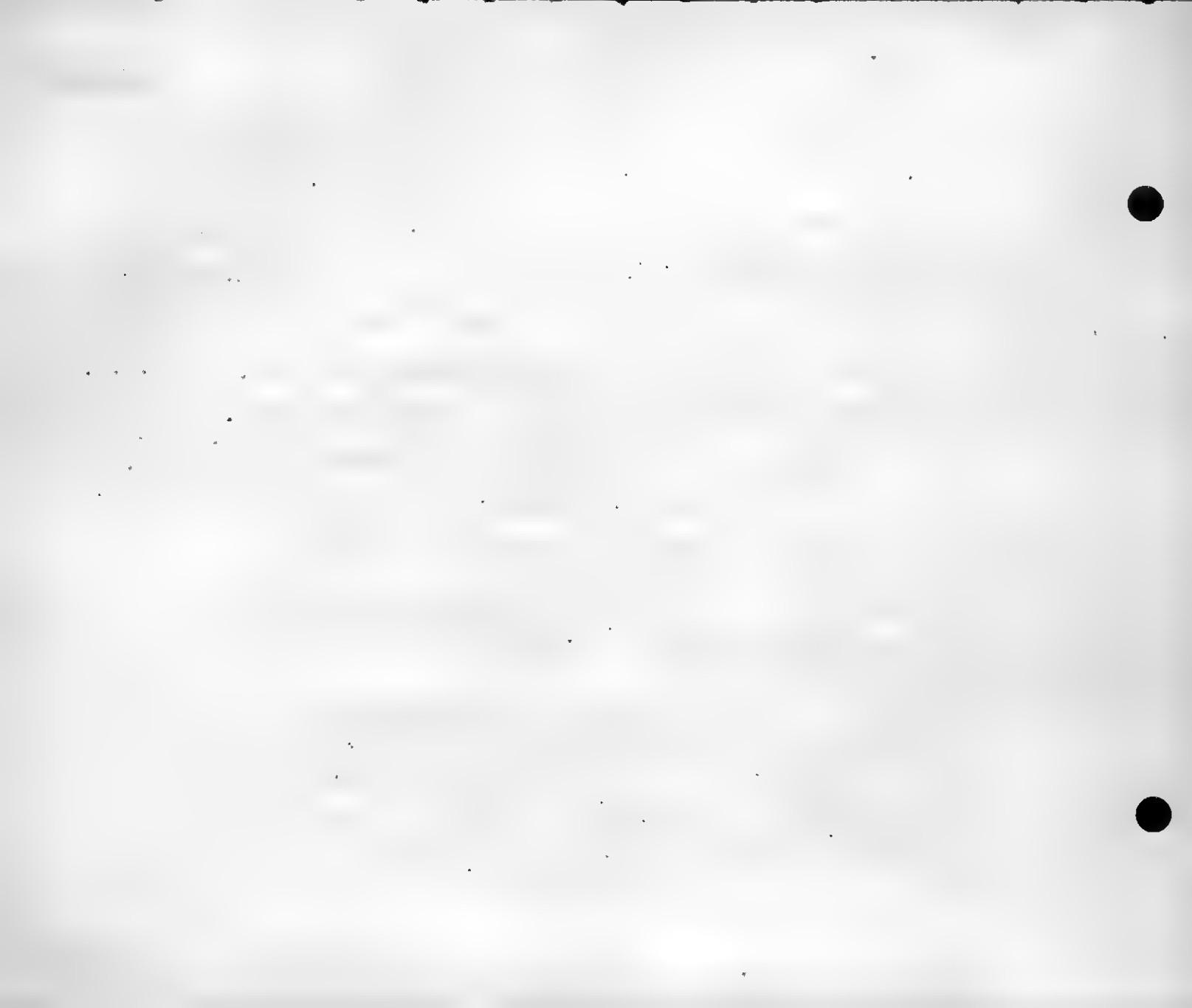
CERTIFICATE OF DEATH

11912

1. PLACE OF DEATH a. COUNTY Talbot		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		c. LENGTH OF STAY IN 1b six weeks		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Delaware		b. COUNTY Kent				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rio Vista Nursing Home		d. STREET ADDRESS 46 S. Governors Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Joseph Rollins Stewart	Middle Last	4. DATE OF DEATH Aug 22 1966	Month 19	Day	Year						
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 1 1885	9. AGE (In years if under 1 year, if under 24 hrs. last birthday) 80 yrs.	Months	Days	Hours					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Gas Stations		11. BIRTHPLACE (County & State, or foreign country) Talbot Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Samuel Thomas Stewart		14. MOTHER'S MAIDEN NAME Anna J. Richards		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 222-07-7120A						
17. INFORMANT Paul L. Stewart Dover, Del		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cokepid - several mos. DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) carcinoma colon DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) otherosclerosis cardio Vard		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield		20f. (City or town) Dover	(County) Kent	(State) MD
21. I certify that (I) (this hospital) attended the deceased from 8-20 1966 , to 8-27 1966 , that (I) (we) last saw the deceased alive on 8-22 1966 , and that death occurred at 5:34 AM , from the causes and on the date stated above.		22a. SIGNATURE Humphrey		22b. DATE SIGNED 8-29-66								
22c. PHYSICIAN'S NAME (Type) Raymond Reeser Jr		22d. ADDRESS St. Michaels md										
23a. BURIAL, CREMATION, REMOVAL (Specify) 8-30-66		23b. DATE THEREOF 8-30-66		23c. NAME OF CEMETERY OR CREMATORIAL Springfield		23d. LOCATION (City, town or county) Dover		(State) MD				
24. FUNERAL DIRECTOR Wells Clark		ADDRESS Dover, Md		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 30 1966				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

11S18

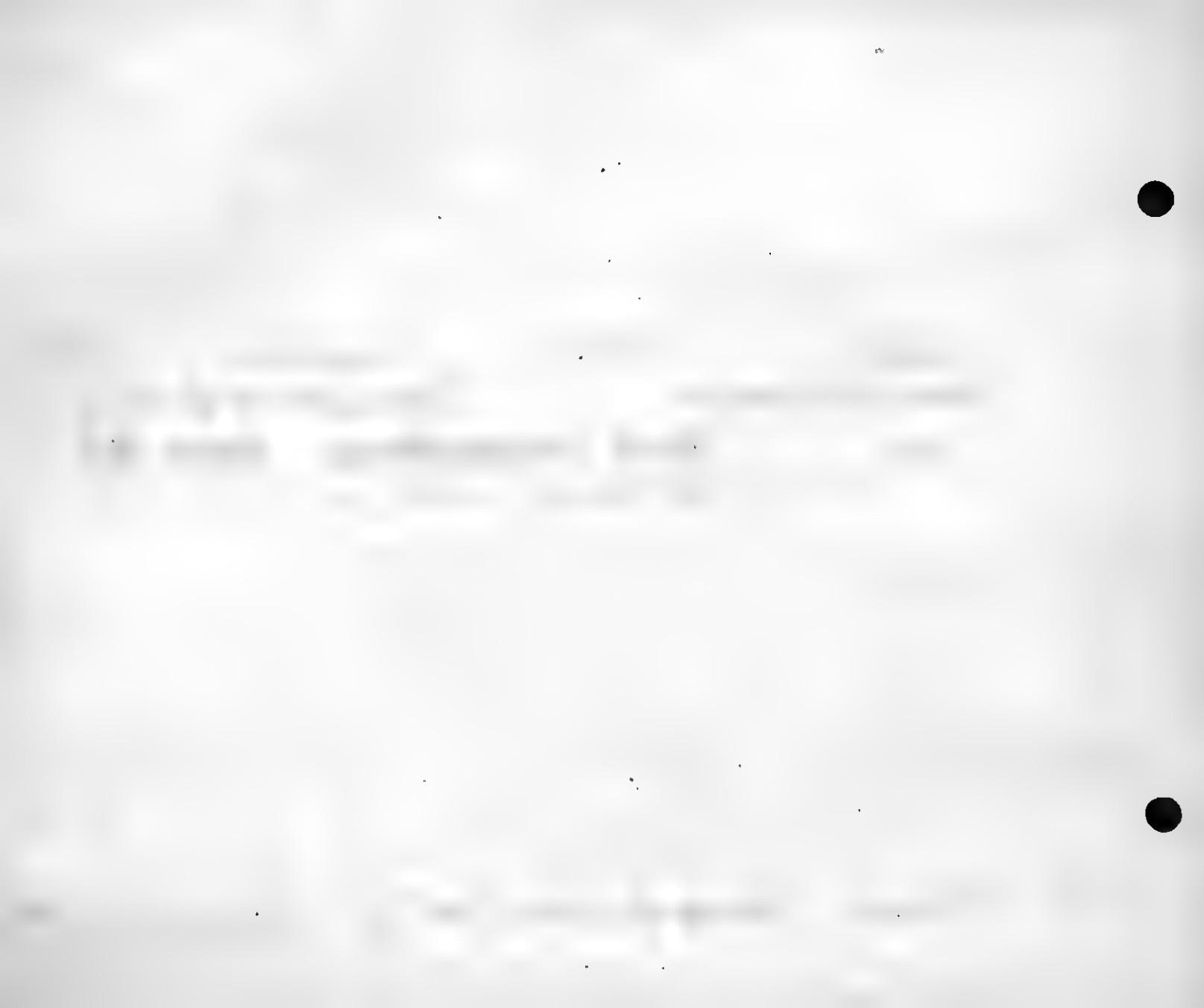
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11913

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>SADIE</u>	Middle <u></u>	Last <u>SULLIVAN</u>
4. DATE OF DEATH	Month <u>8</u>	Day <u>15</u>	Year <u>1966</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/17/98</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
11. BIRTHPLACE County & State (or foreign country) <u>Queen Anne</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WESTLY SMITH</u>		14. MOTHER'S MAIDEN NAME <u>Rose SMITH WISHER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-30-8385</u>	
17. INFORMANT <u>Joseph Records</u>		Address <u>EASTON, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardio vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>A</u> DUE TO (c) <u>trophic left kidney</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> While <input type="checkbox"/> Not White <input type="checkbox"/> p.m. <u></u> at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. INJURY OCCURRED <u>6 PM</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Queen Anne</u> (County) <u>Md</u> (State) <u></u>	
21. I certify that (I) (the hospital) attended the deceased from <u>Aug 16 1966</u> to <u>19</u> , that (II) (we) last saw the deceased <u>Aug 16 1966</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.		22b. DATE SIGNED <u>16 Aug 66</u>	
22a. SIGNATURE <u>E.C.H. Schmidt</u>		22b. DATE SIGNED <u>16 Aug 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		22d. ADDRESS <u>EASTON, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-20-66</u>	
23c. NAME OF CEMETERY OR CREMATORIAL <u>Sandtown Cemetery</u>		23d. LOCATION (City, town or county) <u>Queen Anne Md</u> (State) <u>Md</u>	
24. FUNERAL DIRECTOR <u>James R Dashill</u>		ADDRESS <u>EASTON, Md</u>	
25a. REC'D BY REGISTRAR <u>J Charles Judge</u>		DATE <u>AUG 18 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

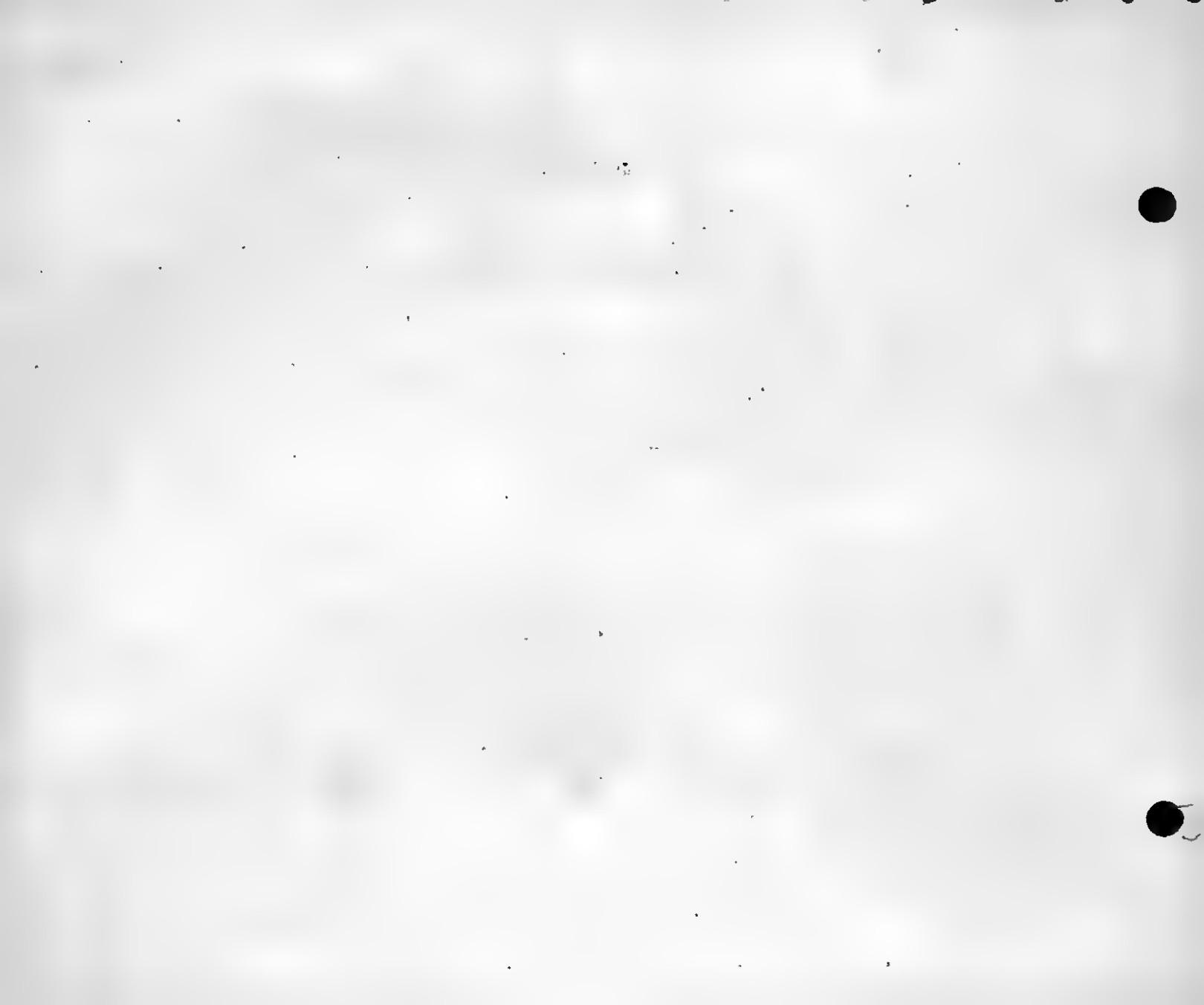
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for us or the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11919 11914

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	c. LENGTH OF STAY IN 1b <i>3 days</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <i>Memorial</i>	d. STREET ADDRESS <i>Bloomingdale Ave.</i>			
3. NAME OF DECEASED (Type or print) <i>W. Towers Todd</i>	4. DATE OF DEATH Month Day Year <i>8 12 66</i>			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 3, 1895</i>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <i>71 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY Retired Farmer	11. BIRTHPLACE (County & State, or foreign country) <i>Caroline Co., Md</i>	12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alva B. Todd	14. MOTHER'S MAIDEN NAME Cora Towers	Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 214-32-7327	17. INFORMANT Mrs. Viola B. Towers Federalsburg,	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>1918</i>		DUE TO (b) <i></i>		
		DUE TO (c) <i></i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bilateral cerebral thrombosis - ill</i>				
20a. ACCIDENT WAS UNDERRING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State)	
19				
21. I certify that (I) (this hospital) attended the deceased from <i>9 July</i> , 19 <i>66</i> to <i>12 Aug</i> , 19 <i>66</i> , that (II) (we) last saw the deceased alive on <i>8-12</i> 19 <i>66</i> and that death occurred at <i>8:30</i> A.M. from the causes and on the date stated above.				
22a. SIGNATURE <i>Thurston Harrison</i>		22b. DATE SIGNED <i>13 Aug 66</i>		
22c. PHYSICIAN'S NAME (Type) THURSTON HARRISON	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>Castro, Maryland</i>		
23a. BURIAL CREMATION, REMOVAL (Specify) <i>8-15-66 Hellcrest Cemetery Federalsburg, Md</i>	23b. DATE THEREOF <i>8-15-66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Hellcrest Cemetery Federalsburg, Md</i>	23d. LOCATION (City, town or county) (State) <i>Federalsburg, Md</i>	
24. FUNERAL DIRECTOR <i>James Williamson Federalsburg, Md</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>AUG 16 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

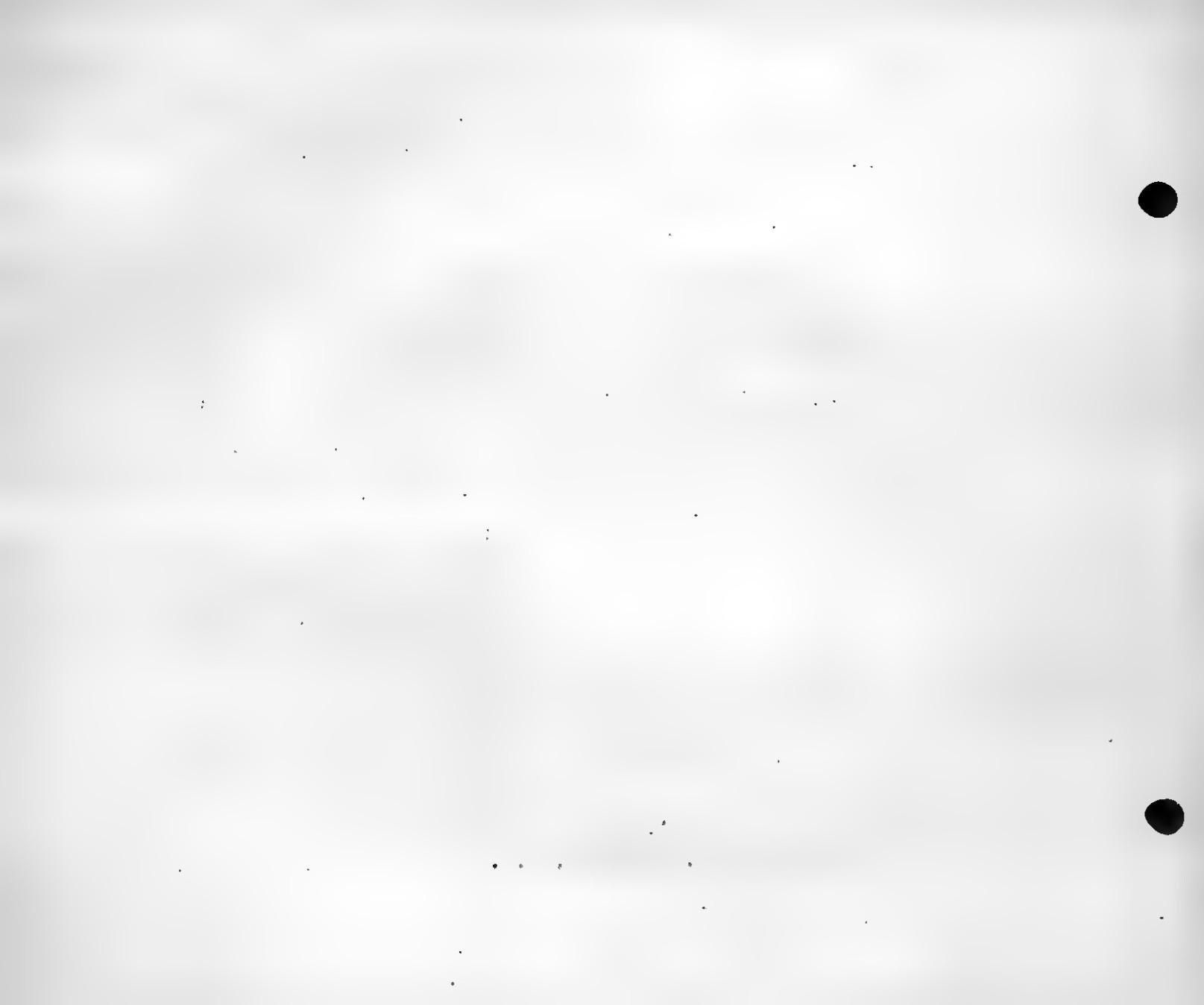
TO FUNERAL DIRECTOR: After this certificate has been signed by the physician or attending physician,

director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11920		11915	
<p>1. PLACE OF DEATH a. COUNTY <i>Falset</i></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i></p> <p>c. LENGTH OF STAY IN 1B <i>3 hours</i></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i></p>		<p>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Queen Anne</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEVENSVILLE</p> <p>d. STREET ADDRESS</p>	
		<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <i>Baby Bay</i> Middle <i>Walbert</i> Last</p>		<p>4. DATE OF DEATH 8 Month AUG. Day 20 Year 1966</p>	
<p>5. SEX MALE 6. COLOR OR RACE WHITE</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p>	
		<p>11. BIRTHPLACE (County & State, or foreign country) MARYLAND</p>	
<p>13. FATHER'S NAME JOSEPH WALBERT</p>		<p>14. MOTHER'S MAIDEN NAME PATRICIA EWING</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. 111-11-1111 17. INFORMANT MRS. JOHN COURSEY - CHESTER MD.</p>	
		<p>Address</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congenital atelectasis</i></p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>16-16 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)</p> <p>DUE TO DUE TO DUE TO</p> <p><i>Prenatal</i></p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.</p>		<p>20d. INJURY OCCURRED while at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>	
		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) S N. Haven</p>	
		<p>20f. (City or town) Stevensville (County) Queen Anne (State) M.D.</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 4:34 P.M. from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE <i>William H. Hatfield</i></p>		<p>22b. DATE SIGNED 8/24/66</p>	
<p>22c. PHYSICIAN'S NAME (Type) William H. Hatfield, M.D.</p>		<p>M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS S N. Haven</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL</p>		<p>23c. NAME OF CEMETERY OR CREMATORIUM STEVENSVILLE</p>	
		<p>23d. LOCATION (City, town or county) STEVENSVILLE (State) M.D.</p>	
<p>24. FUNERAL DIRECTOR Edgar L. Lane</p>		<p>ADDRESS <i>Church Street</i></p>	
		<p>25a. REC'D BY REGISTRAR AUG 30 1966</p>	
		<p>25b. RECHMIR'S SIGNATURE <i>Charles Judge</i></p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

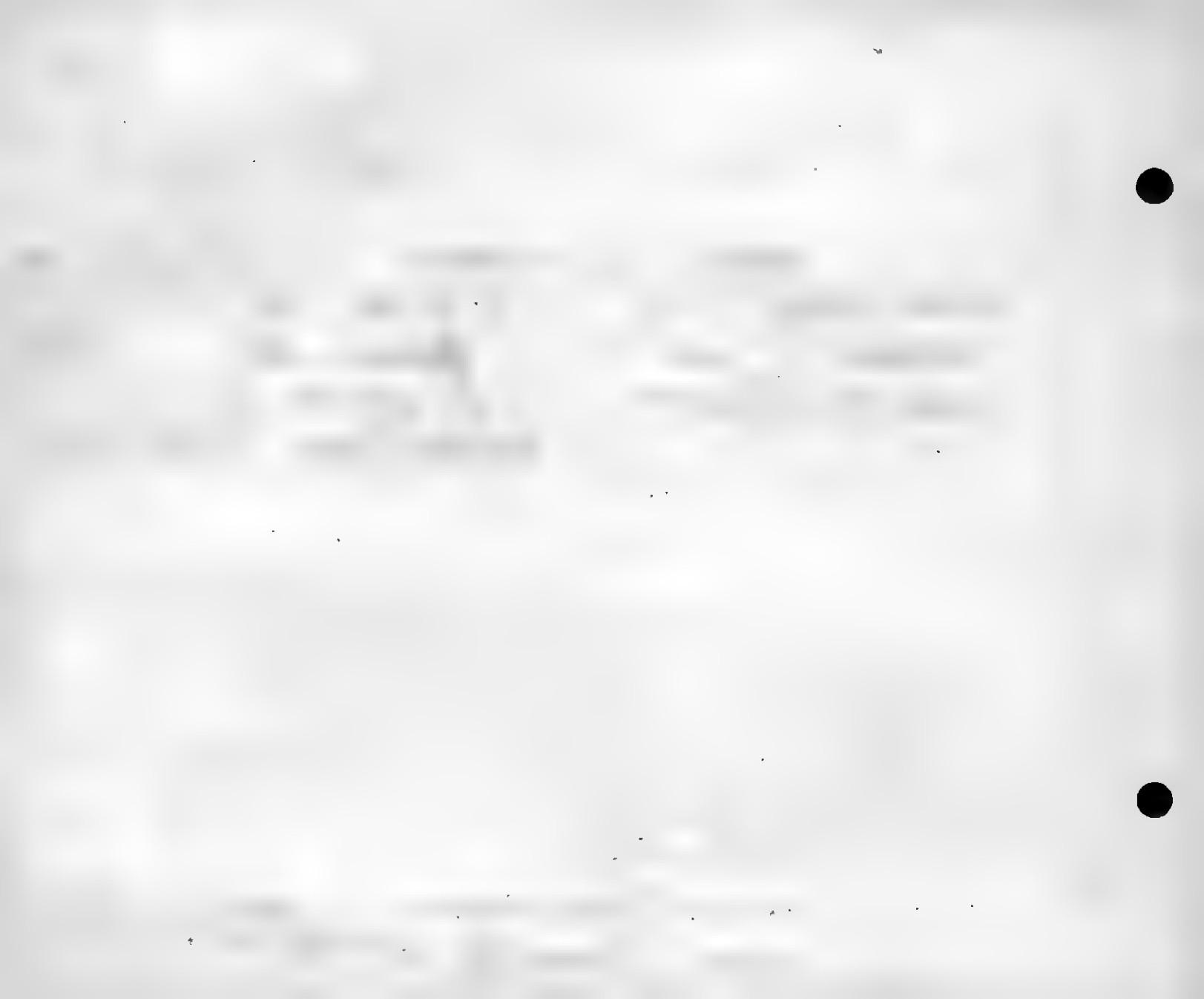
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11916

1. PLACE OF DEATH a. COUNTY		Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		RURAL ST. MICHAEL'S		C. LENGTH OF STAY IN 1b		a. STATE Maryland		b. COUNTY Talbot		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		RURAL ST. MICHAEL'S		
3. NAME OF DECEASED (Type or print)		First MARY	Middle LILLIE	Last WARREN	4. DATE OF DEATH	Month 8	Day 22	Year 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE		6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-9-86	9. AGE (in years last birthday) 80 yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wicomico, Md		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Thomas IRVIN PINKETT		14. MOTHER'S MAIDEN NAME Elizabeth Taylor								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT AUGUSTA Collier		Address St. Michael's, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chadic decompensation 4-6 days Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Anstenic & clausotic cardiovascular disease (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Jan 1967 to Aug 28, 1966, that (I) (we) last saw the deceased alive on (8-23-66), and that death occurred at M, from the causes and on the date stated above.		22b. DATE SIGNED 8-25-66								
22a. SIGNATURE J.E. Fassett		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 8-27-66 Richards Memorial		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county) EASTON		(State) Md		
24. FUNERAL DIRECTOR James B. DASHIELL		ADDRESS EASTON, Md		25a. FUNERAL DIRECTOR'S SIGNATURE		25b. REMASTER'S SIGNATURE				



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5, may be retained for your files.

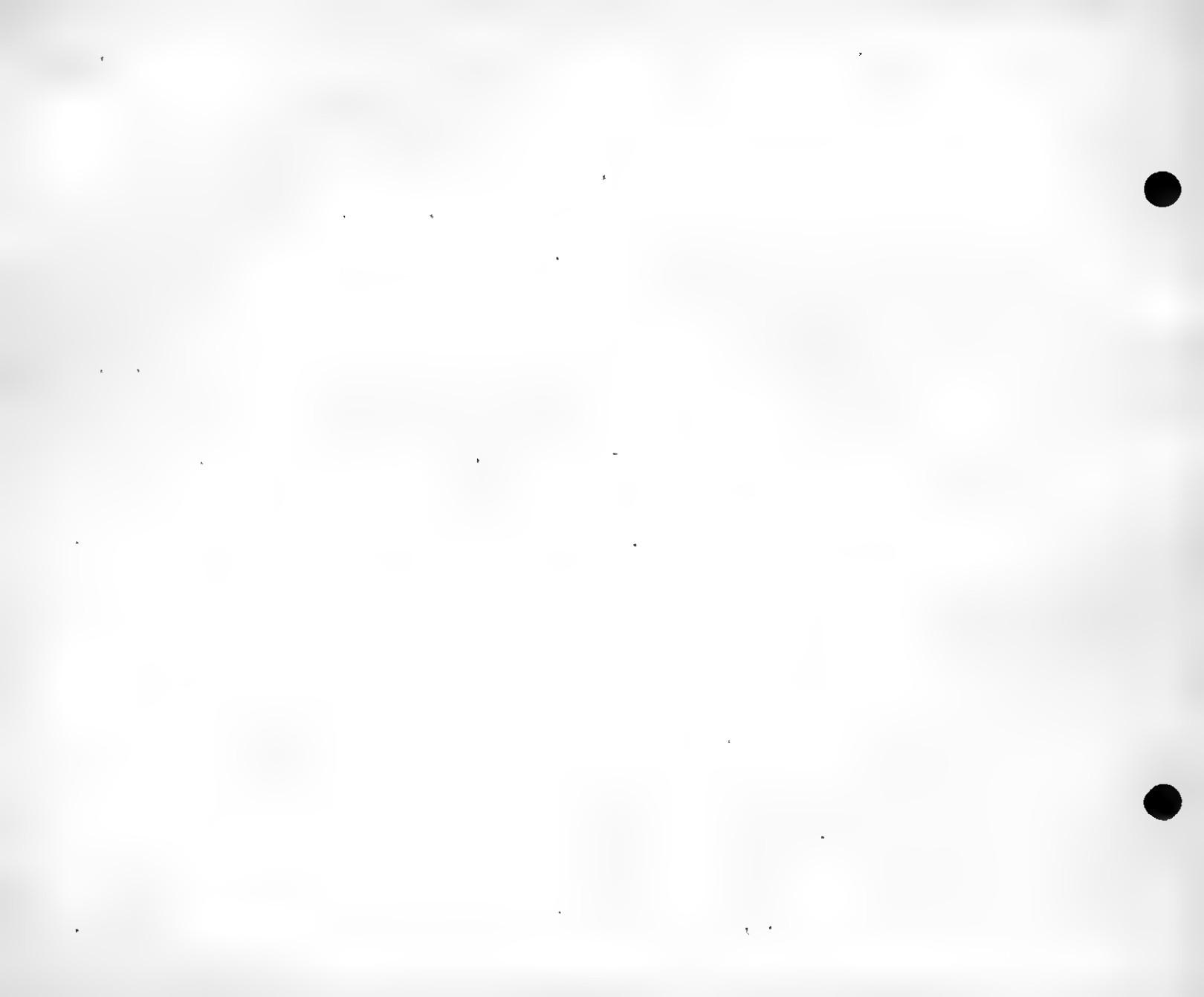
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 4, within 72 hours after death.

11922

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11917

1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cordova		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Talbot	
c. LENGTH OF STAY IN lb unk.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Trappe	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		d. STREET ADDRESS R. D. #1, Box 125	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NORMA LORMINE WHITE		4. DATE OF DEATH August 30	Month Day Year 1966
S. SEX Female	6. COLOR OR RACE white	7. MARRIED # WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 16, 1926
9. AGE (In years last birthday) 40 yrs	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	11. BIRTHPLACE (State or foreign country) New Jersey	12. CITIZEN OF WHAT COUNTRY? U.S.
10a. US-AL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Edgar Ewing		14. MOTHER'S MAIDEN NAME Ruth Talle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 152-18-8069	
17. INFORMANT Mrs. Ruth Ewing		Address Trappe, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 976 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
DUE TO inflicted			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot self in left anterior chest	
20c. TIME OF INJURY Month, Day, Year Hour am 30 Aug 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg etc) Shipton Talbot Maryland
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 30 Aug 66	
ACTUAL SIGNATURE Thorston Harrison		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVALS (if any) Burial		23b. DATE THEREOF Sept. 2, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Windy Hill Cemetery		23d. LOCATION (City or Town) (County) (State) rural Trappe Talbot Md.	
24. FUNERAL DIRECTOR Marvin E. Neumann & Son EASTON, Md.		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS		25b. REGISTRAR'S SIGNATURE SEP 2 1966	



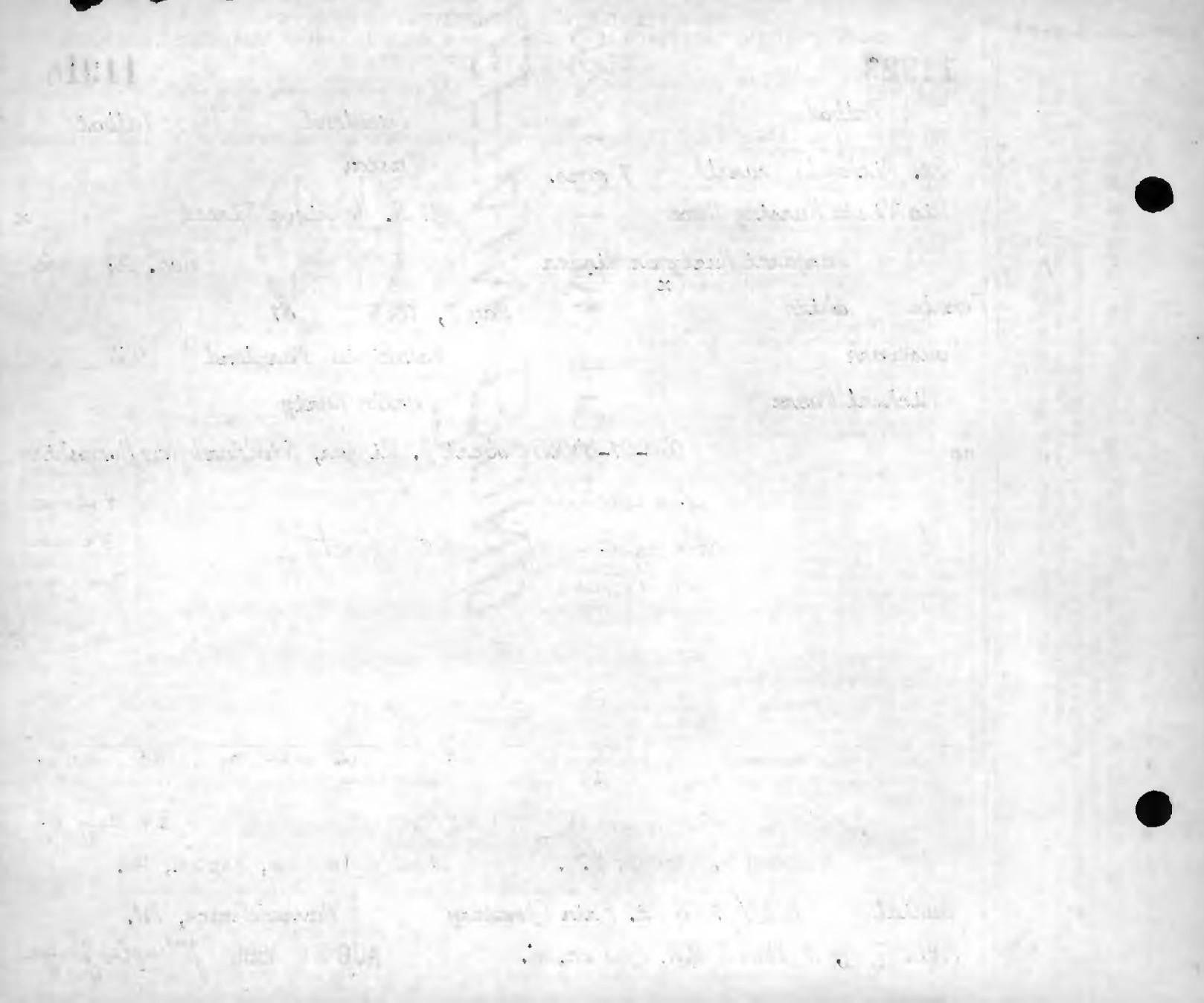
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11923

CERTIFICATE OF DEATH

11918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.		Item 3 Film 6300 9/6/66											
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.													
1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1B		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)		a. STATE		b. COUNTY			
Talbot		St. Michaels (rural)		7 mos.		Maryland		Maryland		Talbot			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
Rio Vista Nursing Home		20-1											
3. NAME OF DECEASED (Type or print)		AKA	First Nan	Middle Moore	Last Wigger	4. DATE OF DEATH	Month	Day	Year				
Margaret Kurtzman Wigger						Aug. 22			1966				
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Hours	12. IF UNDER 24 HRS. Min.		
Female		white					May 7, 1885	81 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Housework				Principio Maryland		USA							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Michael Moore		Martha Kurtz											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
no		060-01-84083		Robert J. Wigger, Stoddard New Hampshire									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4 days											
4501 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Septicemia											
(b)		DANGER of right foot		3 weeks									
(c)		Arterosclerosis		many years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19													
21. I certify that (I) (This hospital) attended the deceased from Feb. 1966, to 22 Aug. 1966, that (I) (we) last saw the deceased alive on 6 Aug. 1966, and that death occurred at 64 M, from the causes and on the date stated above.													
22a. SIGNATURE		22b. DATE SIGNED											
Stephen P. Carney, M.D.		24 Aug 66											
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		Dutchman's Lane, Easton, Md.									
Stephen P. Carney, M.D.													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)					
Burial		8/25/ 1966		Mt. Erin Cemetery		HavredeGrace, Md.							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
MAURICE E. NEUNAM & SON, Easton, Md.				DATE AUG 26 1966		Charles Judge							



1
11924
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												11919			
CERTIFICATE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
1. PLACE OF DEATH a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pages 1 and 2			c. LENGTH OF STAY IN 1b			d. STATE			b. COUNTY			
TALBOT			RURAL - ROYAL OAK			8 years			MARYLAND			MARYLAND	TALBOT		
												C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
												RURAL ROYAL OAK			
									d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or Print)			First			Middle			Last			4. DATE OF DEATH	Month	Day	Year
JOSEPH			HENRY			WATER			AUGUST						22 1966
5. SEX			6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH			9. AGE (in years last birthday)		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
M			W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			MARCH 7, 1900			66 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
SALES MANAGER				LUBRICATION				BALTIMORE, MD.				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME											
JOHN LODGE WATER				SALLIE EMMA CROOKS											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address			
NO				006-10-1264				MRS. J. HENRY WATER				1530 Fairmeadows, ROYAL OAK, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1530 Carcinoma of the colon												2 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ (d) _____ (e) _____ (f) _____ (g) _____ (h) _____ (i) _____ (j) _____ (k) _____ (l) _____ (m) _____ (n) _____ (o) _____ (p) _____ (q) _____ (r) _____ (s) _____ (t) _____ (u) _____ (v) _____ (w) _____ (x) _____ (y) _____ (z) _____															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town)		(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from June, 1966, to Aug, 1966, that (I) (we) last saw the deceased alive on 5 July 1966, and that death occurred at 5 A.M., from the causes and on the date stated above.												22d. DATE SIGNED 8-23-66			
22a. SIGNATURE Stephen P. Carney				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>				M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) STEPHEN P. CARNEY, M.D.				22d. ADDRESS DUTCHMAN'S LANE, EASTON, MD											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF August 24, 1966				23c. NAME OF CEMETERY OR CREMATORIAL WOODLAWN				23d. LOCATION (City, town or county) (State) BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR John J. Easton, Jr.				ADDRESS 1530 Fairmeadows, EASTON, MD				25a. REC'D BY REGISTRAR AUG 25 1966				25b. REGISTRAR'S SIGNATURE Charles Judge			

